



Rotherham Safeguarding Children Board

# Serious Case Review Process

Version 0.6  
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# Contents

Contents	Page:	1
<b>Introduction</b>		4
<b>Section 1 – Practice Guidance on Serious Case Reviews</b>		5
1. Confidentiality		
2. Decision to refer to Standing Serious Case Review Panel		5
3. Standing Serious Case Review Panel		6
4. Initiating the Review		8
5. Establishing the Overview Panel		9
6. Informing the family		10
7. Individual Management Reviews		11
8. Meeting of the SCR Overview Panel		12
9. The Overview Report		13
10 Presentation to the RSCB		14
13 Action Plans		15
14 Coroner and Criminal Court issues		16
15 Action Planning and Review		17
17 Publication of Evaluations		18

<b>Section 2 – Roles and Responsibilities</b>		19
2.1 Rapid Response Team		20
2.2 Child Death Overview Panel		20
2.3 LSCB Chair		20
2.4 Standing Serious Case Review Panel		22
2.5 Designated Senior Managers		23
2.6 SCR Overview Panel		25
Initial Meeting		
Subsequent Meetings		
After the Overview Report is Published – Action Plans		
Multi-agency Debrief Session		
2.7 Chair of Overview Panel		27
2.8 Investigating Manager		28
2.9 RSCB Manager		29
Deciding whether a Serious Case Review is needed		
Once a Serious Case Review has been confirmed		
Overview Panel meetings		
Agency Chronologies		
Agency Management Reviews		
Overview Report & Executive Summary		
Media Activity		
Action Plans		
RSCB Annual Report and Business Plan		
2.10 RSCB		34

<b>Part 3 - Serious Case Review Documents</b>		35
3.1 Serious Case Review Timescale Guide		36
3.2 Draft template for SCR Terms of Reference		38

3.3 Notification letter for SCR to parents/carers	40
3.4 Notification Letter to Designated Senior Managers/ Ofsted	42
3,5 Notification Letter to the Coroner	44
3.6 Standard Template & Guidance for completing Independent Management Reports	45
3.7 Chronology Format and Guidelines	52
3.8 Example of Genogram	54
Letter to Ofsted to accompany Overview Report	55
SCR Action Record	56
SCR File Front Sheet	57
Ofsted Descriptors for the Evaluation of Serious Case Reviews	60

**To be read in conjunction with:-**

- Chapter 19 of South Yorkshire Safeguarding Children Board (Rotherham) Child Protection Procedures 2007
- Working Together to Safeguard Children 2006, HM Government

**This process will be reviewed following the revision of Chapter 8 Working Together to Safeguard Children 2006.**

# INTRODUCTION

1. Local Safeguarding Children Boards (LSCBs) are required to undertake reviews of serious cases. A Serious Case Review is undertaken when a child dies including death by suicide and abuse or neglect is known or suspected to be a factor in the child's death. There are other circumstances when a review should always be considered and these include where a child has received a potentially life-threatening injury and the case gives rise to concerns about the way professionals and services worked together to safeguard and promote the welfare of the children. A SCR should also be undertaken when a parent has been killed in a domestic violence situation and further details can be found in Working Together to Safeguard Children 2006.
2. The aim of this guidance is to ensure clarity, high quality and consistency of practice in carrying out SCRs within the required timescales and to the standards expected by Rotherham Safeguarding Children Board and the Office for Standards in Education, Children's Services and Skills (Ofsted).
3. This process is in line with requirements as set out in Chapter 8, Working Together to Safeguard Children 2006 and LSCB Regulation 5 for undertaking SCRs. The full criteria for undertaking SCRs are within these documents.
4. The Serious Case Review process is described in chapter 19 of the South Yorkshire (Rotherham) Safeguarding Children Board Child Protection Procedures. This Practice guidance complements the procedure and is intended to provide guidance appropriate to the specific needs and role of each individual involved in a SCR.

**Section 1** is an Overview of the Serious Case Review process and Practice Guidance on the completion of SCRs. It provides key information required to carry out the review.

**Section 2** describes the various roles, providing effective checklists for those involved in the review, including Rotherham Safeguarding Children Board (RSCB) Chair, the Overview Panel and RSCB Manager.

**Section 3** includes templates for the documents that are to be used in SCRs from 01.06.09.

# **SECTION 1 - OVERVIEW OF THE SERIOUS CASE REVIEW PROCESS AND PRACTICE GUIDANCE**

## **1. Confidentiality**

- 1.1 Undertaking a SCR is a confidential process. The focus of the Review is to learn lessons following the death of a child or other serious incident and is not a review of the family. However there will be a large amount of information about the child and family life, in addition to details of workers and the practice of agencies and individuals.
- 1.2 All e-documents will be password protected and that password should only be shared with those involved. No document, Individual Management Review (IMR), or the Overview Report should be shared with any person without express permission of the Chair of RSCB. If documentation is shared then the Safeguarding Board Manager is responsible for keeping an audit trail.
- 1.3 Officers receiving copies of the IMRs of partner agencies do not have permission to disclose or distribute these documents. Each IMR remains the property of the commissioning agency. Each IMR should be anonymised and the names of parents involved should be given on a 'need to know basis'.
- 1.4 The Overview Report is the property of the RSCB.
- 1.5 Agencies will follow their own regulations for storage and retention of their drafts and reports as is usual practice. RSCB Manager will ensure that a complete and secure set of documents is maintained for each SCR.
- 1.6 Further information is contained about information sharing in respect of criminal or coronial proceedings at 14 below.

## **2 Decision to refer to Serious Case Review (SCR) Standing Panel**

*[See also Section 2 Role and Responsibilities – Rotherham Child Death Rapid Response Team (RRT) and Rotherham Child Death Overview Panel (RCDOP)].*

- 2.1 Immediately following the death of a child the lead member of the Rapid Response Team or any agency involved should notify the RSCB Manager if there is suspicion that neglect or abuse might be factors in the death and the Manager will inform the RSCB Chair. A briefing note should be forwarded to the RSCB Manager.
- 2.2 The Rapid Response Team will always consider and record whether a referral should be made to the SCR Standing Panel. This discussion should consider whether there are any indications that the criteria for a SCR might

be met, therefore necessitating such a referral. The lead member of the Rapid Response Team should communicate the outcome of this consideration to the RSCB Manager.

- 2.3 RCDOP should similarly consider whether the criteria for a SCR might be met. The Chair of RCDOP should ensure that the decision is communicated to the RSCB Manager.
- 2.4 In addition any agency can refer a case to the Chair of RSCB through the Safeguarding Children Board Unit, if it is believed that the criteria are met and there are important lessons for interagency working, requesting that consideration be given to holding a SCR. The Chair of RSCB will refer these cases to the SCR Standing Panel for consideration, within one week. The RSCB Manager will ensure that Ofsted is notified of the incident that prompted the referral.

### **3 SCR Standing Panel**

*[See also Role and Responsibilities - SCR Standing Panel and Chair]*

- 3.1 SCR Standing Panel will meet as soon as possible following the referral for consideration and always within two weeks.
- 3.2 The primary task for the Standing Panel is to consider the available information in order to make a recommendation to the RSCB chair about whether the criteria to undertake an SCR are met. To undertake this role they will have at their meeting:
  - Copies of the notification document to Ofsted including basic information
  - Notes from the chair where referral is made directly to the chair
  - Copies of notes from related meetings where applicable
  - Updated information from their own agency which they have brought to the meeting and circulated where appropriate, e.g. South Yorkshire Police representative should bring up-dated information on any police enquiries and related findings.
  - Pro-forma for Terms of Reference –See page 38, **3.2**
- 3.3 For the SCR Standing Panel to be quorate the Chair (or their deputy who should be from Police or Children’s Social Care), and representatives from Police, Children’s Social Care and Health must be present. One member can hold more than one role and four individual members must attend. The meeting can be achieved by tele-conferencing to ensure it is held urgently so that a decision can be made by the RSCB Chair within one month of the serious incident coming to their attention. Where this occurs it is the responsibility of the Chair of the SCR Standing Panel to ensure that sufficient information is shared.

- 3.4 The Chair of the SCR Standing Panel will make a recommendation, within one week of the panel meeting, to the Chair of RSCB (via the RSCB Manager) about whether a SCR should be carried out based on the criteria identified in Working Together to Safeguard Children 2006. This written recommendation should include a detailed account of the reasons and any significant factors to assist the RSCB Chair to make the decision.
- 3.5 Where the recommendation is to proceed to a Serious Case Review, the Standing Panel should also recommend an independent chair (where possible), the membership for the SCR Overview Panel and any specialist guidance required. In making these recommendations consideration should be given to the role of the Overview Panel (*see Role and Responsibilities – Overview Panel*).
- 3.6 RSCB Manager will consult and prepare draft Terms of Reference for consideration at the first SCR Overview Panel. Consideration should be given to the potential for completion of the Review within four months of the RSCB chair's decision to hold the review. If it is clear at this stage that the case is very complex, involves a very lengthy history, or there are proceedings in criminal court the SCR Standing Panel should recommend to the Chair of RSCB that extended timescales may need to be negotiated with Government Office of Yorkshire & Humberside (GOYH).
- 3.7 The RSCB Manager, directed by the SCR Standing Panel and the RSCB Chair, will make arrangements for commissioning an independent overview author. The SCR Standing Panel will consider arrangements for commissioning an independent overview author as well as an independent chair for the SCR Overview Panel. It is not appropriate for one person to fulfil both roles (as per guidance issued by the Secretary of State on 16.12.2008).
- 3.8 If the recommendation is that a SCR is not required, the Panel should recommend whether a less comprehensive review or audit should be undertaken. This might be for a review by the RSCB's Practice Standards Sub-committee or for a single agency management review of the case.

### **SCR Standing Panel membership**

3.9 The core membership comprises:

- Nurse Consultant/Director of Public Health NHS Rotherham
- Director of Locality Services, RMBC Children and Young People's Services
- Detective Superintendent, South Yorkshire Police  
(Currently covered by Manager, Public Protection Unit)
- Divisional Manager, National Probation Service
- Deputy Director of Nursing, Rotherham Rotherham and South Humber Mental Health NHS Foundation Trust
- Designated Doctor, Rotherham General Hospital NHS Foundation Trust

- A representative of at least one agency independent of the case which could include RMBC Chief Executive's Office, NSPCC, Barnardos and/or CAFCASS where appropriate
- RSCB Safeguarding Manager (as professional adviser)
- Minute taker from the Safeguarding Children Board

The SCR Standing Panel will be chaired by the RSCB Chair or RSCB Manager. Named deputies should be an exception and agreed with the Chair prior to the panel meeting.

## **4 Initiating the Review**

- 4.1 Designated Senior Managers have an important role in agencies meeting their obligations under this process, ensuring communication, accountability and support for all staff involved. *[See also Role and Responsibilities - Designated Senior Manager]*
- 4.2 The RSCB Manager will write, on behalf of the RSCB Chair, to Chief Officers in all statutory agencies and any other agencies known to have involvement, confirming that a SCR is to take place. Designated Senior Managers are responsible for ensuring that the process within their agency is carried out and managed appropriately.
- 4.3 The commissioning letter will require agencies to secure all records and to ensure the review of all records for their service area to identify any involvement with the family as detailed in the notification letter. They should reply to the RSCB Chair within the timescale stated in the letter.
- 4.4 Copies of this letter will be sent to all RSCB members, the Head of Communications for the Local Authority and the Safeguarding Advisor at Government Office for Yorkshire and Humberside (GOYH). Where the case involves criminal proceedings or death, a letter will also be sent to the Crown Prosecution Service and Coroner
- 4.5 Designated Senior Managers are:
- Director of Locality Services, Rotherham MBC Children and Young People's Service
  - Director of Targeted Services
  - Head of Inclusion, Rotherham MBC Children and Young People's Service
  - Nurse Consultant and Designated Doctor, NHS Rotherham
  - Clinical Director, Rotherham General Hospital NHS Foundation Trust
  - Detective Superintendent, South Yorkshire Police
  - Children's Services Manager, NSPCC
  - Divisional Manager, National Probation Service

- Children and Family Court Advisory Support Service Manager, CAFCASS
- Nurse Director, Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust
- Assistant Director, Action for Children/VCS Forum for Children and Young People
- Director of Community and Wellbeing, Neighbourhood and Adult Services, Rotherham Metropolitan Borough Council

## **5 Establishing the SCR Overview Panel**

*[See also Role and Responsibilities - SCR Overview Panel and Chair]*

- 5.1 The SCR Standing Panel will recommend which agencies should be included in the membership of the SCR Overview Panel.
- 5.2 The purpose of the SCR Overview Panel is to offer expertise and independence and it is the role of members to work together to analyse critically all IMRs findings and to consider recommendations arising from the SCR. Its task is to give an independent overview of how agencies work together.
- 5.3 The individual(s) representing agencies could be the Designated Senior Manager or should be identified by them. It is also important for different professional disciplines to be represented to ensure that the relevant advice and perspective is available to the panel (e.g. both a nurse and a doctor). Where a small number of agencies are involved in the case, other agencies will be asked to provide a representative to ensure independent challenge. Minimum panel size is four.
- 5.4 The Overview Author and SCR Panel Chair must be independent of RSCB and all services involved in the case.
- 5.5 The Overview Panel will be quorate when there are members present from four different agencies, in addition to the Chair.
- 5.6 The SCR Overview Panel chair and members will need to prioritise this work to ensure compliance with the timescales agreed within the procedures and the specific Terms of Reference.
- 5.7 The SCR Overview Panel will finalise and agree the Terms of Reference and the scope of the review. Investigating Managers who author IMRs need the Terms of Reference in order to proceed with their investigations and chronologies. Delay in preparing them will delay timescales. *Consideration should be given to extending the scope of the review to ensure that the investigation into the death and the work of the Rapid Response Team is included.*

## 6 Informing the family

- 6.1 The Terms of Reference will identify the family members to be informed and interviewed as part of the Review. This will almost always be parents and those with parental responsibility for the child or children subject of the Review. It may also be grandparents or other relatives who are, or have been, involved significantly with the immediate family, foster or immediate carer.
- 6.2 The Chair of the Overview Panel will ensure that the family is informed that a review is to take place and that they can be interviewed by the most appropriate professional. (Template 2 in section 3 is the letter for family notification). This professional will normally be the Independent Overview Report Author accompanied by another worker who may be known by the family.
- 6.3 Letters to family members should normally be hand delivered by someone who is briefed adequately to inform and support them at this time. The information leaflet 'What is a Serious Case Review?' should accompany the letter. It is likely to be helpful to involve a professional known to them. (Where there are criminal proceedings this will almost always be undertaken by family liaison officers of South Yorkshire Police. Where criminal proceedings are not taking place, this could be a member of the RSCB Unit or the Operational Safeguarding Unit. The person who delivers the letter should be someone who supports them throughout the process. This could include informing them of the outcomes from the SCR and sharing with them the Executive Summary. The letter will include the name and contact details of the RSCB Manager and the person who will be the link and support for the family members.
- 6.4 It will be important to enable the family to contribute its views if it so wishes. Family members should be clear that:
- the SCR is a review of agency and system performance and effectiveness through which staff are encouraged, as part of a learning process, to reflect critically on their practice.
  - As it is not a public enquiry, staff have an expectation of confidentiality in the process, and this will affect the level of detailed information that will be shared with the family at the conclusion of the Review.

## **7 Individual Management Reviews**

*(See also Role and Responsibilities - Investigating Managers and also in Working Together to Safeguard Children 2006, Chapter 8).*

7.1 The following will be circulated to Investigating Managers as soon as they are available:

- Copy of SCR Process
- Terms of Reference
- IMR template and guidance (template 6)
- Example Genogram
- Chronology template and guidance (template 8)
- Action Plan template and guidance (template 9)
- Arrangements for briefing

7.2 The IMR author, once appointed should access the secured records of their agency and begin to prepare a chronology of events using the template and guidance within this process document.

7.3 The Terms of Reference will detail the agencies and set out the time frame that is to be considered. Normally there will not be any requirement to gather any information outside this scope. However, it may be that the Investigating Manager identifies an important factor that is of a fundamental interest to the review. Similarly the Investigating Manager may wish to summarise important information that pre or post-dates the scope of the Review.

7.4 The chronology should be forwarded as soon as possible to the RSCB Manager (before the Individual Management Review report is written) and should then be included at the end of the completed report so that work can begin on preparing a composite chronology.

7.5 The IMR author should identify any staff members whom they need to interview in order to clarify any issues to complete the investigation. Interviews are conducted in this process as a means of clarifying the agency involvement, and reflecting on an objective and analytical assessment of that involvement. Although SCR interviews will not be used as a disciplinary interview; they inevitably can be stressful for staff, who may wish to bring a professional friend (their role is to provide emotional support to the individual) to the interview with them for support. The professional friend should not be a Trade Union representative. Should the IMR author become aware of practice that they consider to require consideration within disciplinary or competence procedures they will need to follow organisational procedures. A leaflet is available for staff interviewed as part of a Serious Case Review and this is included on page 59 of this procedure.

- 7.6 A Report should be written using the template and guidance supplied.
- 7.7 The IMR author may be required to attend a meeting of the SCR Overview Panel in order to answer questions or clarify matters.
- 7.8 Any difficulties in meeting timescales should be communicated, as early as possible with their agency's Designated Senior Manager. (Investigating Managers need to be aware how their work fits into the whole programme e.g. the timescales for creating the merged chronology being dependent on each agency's chronology being available).
- 7.9 The IMR should be a 'stand alone' document encapsulating information from the chronology in summarised form sufficient for the facts of the family history and agency involvement to be clear. Each IMR will be evaluated by the Overview Report Author. If the IMR is assessed as inadequate, the Overview Panel Chair (via the RSCB Manager), will arrange for work to be undertaken to ensure the required standard is achieved.

## **8 Meeting of the SCR Overview Panel**

*(See also the roles and responsibilities - SCR Overview Panel and Chair)*

- 8.1 At the first meeting, the SCR Overview Panel will confirm the Terms of Reference for the review - scope, timescales, outline of process and resultant schedule of meetings - clarify what will be considered at each meeting, bearing in mind the timescales for completion of chronologies and management reports from individual agencies. At subsequent meetings the merged chronology, identifying key issues for RSCB and/or individual agencies, decision-points, inconsistencies between agencies and good practice will be reviewed.
- 8.2 The Chair of the SCR Overview Panel, together with RSCB Manager, will make arrangements for an early briefing session of Investigating Managers.
- 8.3 The reading, review and quality assurance of Individual Management Reports is time consuming and important, a task for which time must be allocated. Panel members should have regard that their task is to recommend the SCR Overview Report to the RSCB, accepting that it is a rigorous review following guidance as set out in Chapter 8 of Working Together to Safeguard Children (HM Government, 2006).
- 8.4 The Independent Overview Author should be invited to all meetings once appointed.
- 8.5 If, during the course of the Overview process, it becomes clear that the timescales for completion cannot be met, the Chair of the SCR Overview Panel should inform the Chair of RSCB. The RSCB Manager will liaise with the Safeguarding Adviser from Government Office, outlining the reasons for potential delay and requesting extensions to timescales as appropriate.

- 8.6 The IMR author will be invited, as necessary, to attend meetings in order that they can be asked about specific issues in their reports. Dependent on practicalities (usually of time) the SCR Overview Panel may require them to attend together or separately. IMR author will not be Panel members. Consideration must be given by the Chair of the SCR Overview Panel to ensure all IMR authors have equal opportunity to share their views with the Panel.
- 8.7 Meetings will normally be minuted by staff of the Safeguarding Board Unit. In addition the minute taker will complete the Actions from Overview Panel meeting document for immediate distribution.
- 8.8 The Panel will review each agency Individual Management Review ensuring practice issues have been identified, checked out with staff where relevant and addressed in the report, leading to appropriate recommendations for the agency. The Panel will also review each Individual Management Review in the light of findings from the merged chronology.
- 8.9 The Overview Panel is responsible for the quality of the IMRs and will be expected to confirm and challenge agency reports to provide clarification or improve the rigour of reports. Panel members will be expected to have a range of questions across all IMRs to establish appropriate challenge.
- 8.10 Lessons and recommendations emerging from the overview process, either for individual agencies (additional to those identified in their own report) or for the RSCB, to improve the multi-agency process should be identified and acted upon.
- 8.11 The Panel should ensure that recommendations are SMART –specific, measurable, accurate, realistic and time limited. They should include details of the post holder who will be responsible for implementing the recommendations.

## **9 The Overview Report**

- 9.1 This should be written by an Independent Overview Author with relevant experience and expertise.
- 9.2 Commissioning arrangements for the author should follow the accepted procurement guidance. The Overview Panel Chair and the Strategic Director of Children and Young People's Services, advised by the RSCB Manager, should satisfy themselves as to the suitability of the Independent Overview Author for the task. A minimum requirement is approval of a Curriculum Vitae (CV); two references and confirmation of a clear and satisfactory Enhanced Criminal Records Bureau check.
- 9.3 The Overview Report should be written with reference to Chapter 8 of Working Together to Safeguard Children (HM Government, 2006), page 177.

Recommendations should be few in number, focused, specific and capable of being implemented and audited.

9.4 The SCR process could be enhanced by accessing information that becomes available following criminal proceedings. It is, therefore, unusual for a Review and Overview Report to be concluded before the end of such proceedings. Family members should not be interviewed whilst criminal proceedings are on-going. Application for extension of timescale should be made to the Safeguarding Adviser at GOYH.

9.5 The Overview Report will include:

- recommendations from single agency Management Reviews
- recommendations from the Overview Panel for single agencies
- recommendations from the Overview Panel for the RSCB, relating to multi-agency processes; training etc

9.6 The RSCB Chair should review the draft Overview Report and have opportunity to comment before the report is presented to RSCB.

9.7 An Executive Summary should be extracted from the Overview Report, as agreed by the Overview Panel, at its initial meeting. The Children and Young People's Service Communication Manager and the RSCB Manager will usually prepare the Executive Summary in liaison with the Overview author. The draft Executive Summary if possible will be shared with the subjects of the review prior to being placed in the public domain. The purpose of the Executive Summary is to place information in the public domain that gives people confidence that RSCB has systematically and rigorously reviewed what has happened and is taking appropriate action. It needs to demonstrate:

- The integrity of the process
- The key lessons which have been learned
- Recommendations are implemented and have positive impact.

9.8 It is not aimed at the professionals involved in the case who should have access to single and multi-agency debriefs and possibly, the Overview Report (subject to appropriate confidentiality agreements).

## **10 Presentation to the RSCB**

10.1 The SCR Overview Panel recommends the Overview Report, Executive Summary and Action Plan to the RSCB. These documents will be circulated to RSCB members in time for consideration before the report is discussed at a RSCB meeting.

10.2 The Independent Overview Author and/or the SCR Overview Panel Chair will be invited to present the report and be included in the discussion. The RSCB may suggest minor amendments prior to accepting the report as

recommended by the SCR Overview Panel. The RSCB Chair will resolve any disagreements.

## **11 Debriefing session**

- 11.1 It is good practice for each agency to hold an internal de-briefing between the IMR writer, Overview Panel Member and/or Designated Senior Manager at the conclusion of the IMR.
- 11.2 Once the Overview Report is complete, RSCB will hold a multi-agency debriefing session, led by the Chair of the Overview Panel supported by one or more members of the panel. This is aimed at staff who worked with the family during the period covered by the review, rather than at those who have investigated the case.

## **12 Distribution and dissemination**

- 12.1 The RSCB Manager will ensure that the final versions of the Overview Report, Individual Management Reviews, integrated chronology; Executive Summary and Action Plans are sent to Ofsted and a copy of the overview report to the Department for Children, Schools and Families' (DCSF) Safeguarding Unit and Government Office for Yorkshire and the Humber.
- 12.2 Once the Executive Summary has been approved by the RSCB, Chair of the SCR Overview Panel will arrange for it to be shared with the family in advance of it being made public.
- 12.3 RSCB and Rotherham Children and Young People's Board may need to consider how public relations issues will be dealt with well in advance of the publication of the Executive Summary. A media management strategy will be prepared as required.
- 12.4 As soon as possible after Ofsted's evaluation, the Executive Summary will be made available on the RSCB website.

## **13 Action Planning and Review**

- 13.1 All Investigating Managers and Designated Senior Managers should give careful consideration to the recommendations and actions. Actions should be SMART and outcome focused.
- 13.2 The Overview Panel will ensure that agency and RSCB action plans are rigorous and fit for purpose. They should also be checked for consistency with existing procedures and guidance. Where the SCR or an IMR is assessed as inadequate the Standing Panel will reassess the action plan to ensure any new recommendations are captured.

- 13.3 The Standing Panel and the Practice Standards Sub-committee will oversee the implementation of Action Plans and the RSCB Manager will provide regular progress reports to RSCB.
- 13.4 Agencies should submit update forms as required to the Safeguarding Children Board Manager for reports to the Chair and Board. The Safeguarding Board Manager will liaise with GOYH until agreement is reached that the Action Plan has been implemented fully. The Chair of the Safeguarding Children Board will report annually to the Children and Young People's Board on progress in respect of any Serious Case Reviews.
- 13.5 Where a number of SCRs have been completed the RSCB Manager should review these together to ensure themes are identified.
- 13.6 Themes and actions identified by SCRs will be considered by the RSCB Learning and Development sub-committee to ensure they are captured in on-going training programmes, and briefing sessions on lessons to be learned are established as required.

## **14 Coroner and Criminal Court issues**

- 14.1 SCRs are undertaken to establish what can be learned and to see how effectively people from all agencies are following procedures and communicating with each other. It is important to note that the chronology is made up of the author's findings on available information, not a statement of the 'facts' and should not be viewed as primary evidence.
- 14.2 The SCR process could be enriched by accessing information that becomes available following criminal proceedings. It is, therefore, unusual for a Review to be concluded before the end of such proceedings. Family members should not be interviewed whilst criminal proceedings are on-going. Application for extension of timescale should be made to the Safeguarding Adviser at Government Office.
- 14.3 The SCR Overview Panel will need to consider Public Relations and Media issues that might occur at the time of any criminal proceedings and develop a strategy in partnership with South Yorkshire Police and media/communications managers in partner agencies.
- 14.4 In completing SCRs, the following should be considered:
- The Police are key as to how information is disclosed to the Coroner or Courts (where applicable).
  - It is vital that the RSCB Chair is consulted before any disclosure.
  - All those involved in and contributing to a review should be aware that there are precedents where information contributed has been used during an inquest.
  - The RSCB Manager and Chair are made aware of any Freedom of Information requests as soon as possible to allow appropriate

advice to be taken and the RSCB Freedom Of Information protocol should be followed.

- The language used in reports and in Serious Case Review Panel notes should reflect the possibility of Freedom of Information requests.
- A standard description of what a Serious Case Review is for should be included on the front cover of all reports.

## **15 Action Planning and Review**

- 15.1 Once the Overview Report and Executive Summary have been accepted by RSCB, the RSCB Manager will write to the designated senior managers in relevant agencies requesting that their action plans are compiled (using a standard format supplied by the RSCB Manager) addressing their own and the Overview Panel recommendations. Action Plans need to be SMART and outcome focused.
- 15.2 The Overview Panel will meet to ensure that agency and RSCB Action Plans are rigorous and fit for purpose. They should also be checked for consistency with existing procedures and guidance.
- 15.3 The RSCB will agree the Action Plans and review them at agreed intervals via the relevant sub-committee.
- 15.4 Actions for the RSCB will be incorporated into the RSCB Business Plan, where appropriate, at the annual review.
- 15.5 Where a number of Serious Case Reviews have been completed the RSCB should consider reviewing these together to ensure themes are identified.
- 15.6 Themes identified by Serious Case Reviews will be picked up by the RSCB's Safeguarding Training programme, via management teams, seminars, and potentially at RSCB Conferences.

## **16 Evaluations and the Review of Inadequate Serious Case Reviews**

In December 2008, DCSF published guidance in respect of action required by Safeguarding Children Boards where a review is judged to have been 'inadequate' by Ofsted. Rotherham Safeguarding Children Board is committed to ensuring that this situation does not arise in the future. However, should a Serious Case Review be evaluated as 'inadequate', the Safeguarding Children Board in consultation with the Children and Young People's Board will follow the guidance issued in December and further guidance which is anticipated in the near future. When further guidance is received, it will be incorporated into this section of the procedure.

## **17 Publication of Evaluations**

As soon as the evaluation is released by Ofsted this should be communicated to all members of the Overview Panel and members of the RSCB.

It is good practice that evaluation authors are met by the DCS, the Chair of RSCB and the RSCB Business Manager to discuss the evaluation. This should happen regardless of the grade given.

## Section 2 Roles and Responsibilities

<b>Part 2 – Roles and Responsibilities</b>
Rotherham Child Death Rapid Response Team (RRT)
Rotherham Child Death Overview Panel (RCDOP)
RSCB Chair
Standing Serious Case Review Panel
Designated Senior Managers
Serious Case Review Overview Panel
Chair of Overview Panel
Independent Management Report Author
RSCB Manager
Deciding whether a Serious Case Review is needed
Once a Serious Case Review has been confirmed
Overview Panel meetings
Agency Chronologies
Agency Management Reviews
Overview Report & Executive Summary
Media Activity
Action Plans
RSCB Annual Report and Business Plan
RSCB

## **2.1 Rotherham Child Death Rapid Response Team (RRT)**

The person leading the Rapid Response Team should:

- Ensure that the RSCB Manager is informed as soon as possible following the death of a child where factors of abuse or neglect are suspected.
- Consider at every meeting, from initial gathering of information to final findings, whether there are indicators that a SCR should be considered by the SCR Standing Panel. The RSCB Manager should be informed of the outcome of this discussion.
- Identify a member of the Rapid Response Team to present relevant information with the SCR Standing Panel where a case has been referred.

## **2.2 Rotherham Child Death Overview Panel (RCDOP)**

- The Panel should consider routinely whether any child deaths under review have factors of abuse or neglect which means they should be considered at the SCR Standing Panel.
- The Panel Administrator, on behalf of the RCDOP Chair, should communicate with the RSCB Manager about any such death.
- Child Death Overview Panel case update should be included at every Serious Case Review Standing Panel and subsequently made available at each Board Meeting.

## **2.3 RSCB Chair**

Following the referral of a case for consideration for Serious Case Review, the RSCB Chair will:

- Review the recommendation of the Serious Case Review Panel as to whether a Serious Case Review is appropriate and makes the final decision.
- Instruct the Safeguarding Children Board Manager to commission a SCR:
- Arrange for letters to be sent to Designated Senior Managers in all agencies and to other organisations, identified by the Serious Case Review Panel, requesting IMRs.
- Arrange for notification to Ofsted's National Business Unit (NBU) – Tel: 08456 40 40 40 – that a Serious Case Review is to take place and inform them if there are any immediate reasons why the review may take longer than the prescribed time-scales.
- Consider if anyone else needs to be informed e.g. GOYH, DCSF, Strategic Health Authority, as appropriate.
- Confirm that DCSF Children's Safeguarding Unit is notified immediately of all deaths of looked after children.

- Confirm DCSF Early Years Unit and Ofsted are informed if children's day care or childminding is involved.
- Confirm DCSF is informed if a school is involved.
- Confirm that the Strategic Health Authority is informed if there are significant health issues.

The RSCB Chair will also:

- Agree arrangements with the RSCB Manager to ensure that the family is informed appropriately that a review is taking place.
- Monitor the progress of the review and negotiate extensions with GOYH if necessary.
- Update the Strategic Director of Children and Young People's Services and the Children and Young People's Board about progress of Serious Case Reviews.
- Ensure that the Overview Report, Individual Management Reports, the Integrated Chronology and, when available, Executive Summary are sent (by the RSCB Safeguarding Board Manager) to Ofsted and to the DCSF Children's Safeguarding Unit (CSU).
- Present the Executive Summary to the Children & Young People's Board if required to do so.
- Liaise with the Chair of the Overview Panel to ensure that the family is informed of findings of the review.
- Take a key role in any press conferences or other media activity arising from the Serious Case Review following consultation with RSCB member agencies and communications departments.
- Write to the Senior Designated Managers in contributing agencies requesting the completion of their action plan.
- Monitor the progress of agency action plans through RSCB.
- 'Sign off' the Serious Case Review as complete.

## 2.4 Standing Serious Case Review Panel

The Standing Serious Case Review Panel will:

- Meet within four weeks of a case being referred to the RSCB Chair for consideration of Serious Case Review. Four members must attend or participate via tele-conferencing for the meeting to be quorate.
- Make a recommendation to the RSCB Chair as to whether a Serious Case Review is appropriate.
- Identify as far as possible, which agencies should be represented on the Overview Panel and whether any specialist knowledge is required for the case.
- Identify as far as possible, which agencies/organisations should be asked to contribute management reports
- Define the scope of the review, as far as possible, depending on information available, including:-
  - period to be reported
  - whether the review should include information on siblings and family members
  - draw up draft terms of reference, to be ratified by the Overview Panel at its first meeting.
  - if recommending a Serious Case Review, agree a password to be used by all agencies to protect documents during the case.

If at this stage it is clear that the case is very complex or involves very lengthy history, the Serious Case Review Panel should recommend to the Chair of RSCB that extended timescales may need to be negotiated with GOYH.

If the recommendation is that a Serious Case Review is not required, the Serious Case Review Panel should recommend whether a less comprehensive review or audit should be undertaken, e.g. review by the Practice Standards Sub-group of the RSCB or single agency management review.

## 2.5 Designated Senior Managers

### *At the start of a Serious Case Review*

The RSCB Manager will write to inform all Designated Senior Managers of a Serious Case Review.

The Designated Senior Manager should then, with some urgency :-

- ensure relevant files are secured.
- identify their agency's representative(s) to sit on the Overview Panel.
- identify an Independent Author to undertake the Management Review and, if possible, ensure that this person is available for the briefing session .
- where relevant, inform the RSCB Chair and RSCB Manager who has been identified to sit on the Overview Panel (supplying an e-mail address and telephone number if not a RSCB member).
- inform the RSCB Chair and RSCB Manager who has been identified to investigate the case.
- inform staff members who are involved in the case that a Serious Case Review is taking place.

The first meeting of the Overview Panel will need to be organised as soon as is possible (always difficult at short notice) so **a rapid response is vital**.

The time-scale for submission of the chronology and management review will also be tight and work needs to be started promptly.

### *During the course of the review*

The Designated Senior Manager should:

- arrange suitable supervision and support for the manager in undertaking the review.
- pass information and, in particular, formats and guides, from the RSCB Manager on to the Investigating Manager.
- monitor progress and ensure any predicted delays are immediately reported to the RSCB Chair and RSCB Manager.
- attempt to resolve any difficulties in completing the work to timescales.
- sign off and quality control the Independent Management Report before it goes to the Overview Panel (a signed copy will be held on file).
- identify and act on any urgent action identified as needed to address issues of concern arising as the Management Review progresses.

- ensure that, on completion of the Management Review, staff are debriefed and receive feedback, prior to the completion of the Overview Report
- on publication of the Overview Report, share information with staff, ensuring appropriate support is available.
- with the Investigating Manager, identify staff who had direct involvement with the child/family during the period covered by the review and ensure that these staff are informed of, and encouraged to participate in, the multi-agency debrief session.
- ensure action plans are drawn up when requested.
- ensure that recommendations are implemented.
- sign off the action plan when all actions have been completed to their satisfaction.
- endeavour to identify outcomes for service users and staff resulting from the Serious Case Review.
- ensure that recommendations are acted upon.
- sign off the action plan when all actions have been completed to their satisfaction.

## 2.6 Serious Case Review Overview Panel

The Serious Case Review Standing Panel decides the agency membership of the Overview Panel.

The Senior Designated Manager nominates the individual (or occasionally, where representation is needed from different disciplines, individuals) who represents the agency.

The Overview Panel must have four agency representatives to be quorate.

### ***Initial Meeting***

At its first meeting, the Overview Panel should, with close reference to the *South Yorkshire Safeguarding Board Child Protection Procedures and, Part 1 – Practice Guidance on Serious Case Reviews*, page 5 of this document,

- ratify the terms of reference for the review
- agree meeting dates for the review
- clarify what will be considered in each meeting bearing in mind the timescales for completion of chronologies and management reports provided to individual agencies and outlining a work plan
- clarify any issues around confidentiality, including how much information may be sought about parents in the case and implications for staff, families and council members. [See *Working Together to Safeguard Children 2006*, 8.32 and 8.33]
- agree a response to likely media interest and, if necessary, how to brief the Communications team
- consider who is to extract the Executive Summary from the Overview Report
- the meeting should be minuted.

### ***Subsequent Meetings***

Subsequent meetings will, as far as possible, follow the work plan identified. If changes to the schedule are anticipated, the Chair of the Overview Panel should write to the Chair of RSCB, outlining the reasons for potential delay.

At these meetings, the Overview Panel will

- review the merged chronology.
- review Individual Management Reviews.
- identify any further work needed from any agency to provide clarification to the Overview Panel, or improve the rigour of reports.
- identify lessons and recommendations emerging from the overview process.
- review the first draft of the Overview Report, before it is presented to RSCB.

The Chair of the Overview Panel should make their own notes and a member of the panel should note action points for circulation following the meeting using agreed format.

### ***After the Overview Report is Complete – Action Plans***

Following completion of the Overview Report, the RSCB and agencies will be required to produce Action Plans. The Overview Panel should meet again to:

- ensure that action plans are rigorous and fit for purpose and that they are consistent with existing action plans, procedures and guidance.

### ***Multi-agency Debrief Session***

A multi-agency debrief session should be held following all Serious Case Reviews. This will usually be led by the Chair of the Overview Panel, with the support of one or more members of the panel.

## 2.7 Chair of Overview Panel

An Independent Chair of the Overview Panel from outside Rotherham will be agreed subject to confirmation by the RSCB Chair. The Chair must always be independent of involvement in the case and of all the agencies involved in the case and the Serious Case Review Panel.

The Chair of the Overview Panel will

- ensure, with the RSCB Manager, that the family is informed that a review is taking place.
- chair meetings of the Panel, which will be minuted by the RSCB Administrator.
- check, amend and accept the minutes and actions from each meeting of the Overview Panel.
- liaise with the RSCB Manager as necessary to ensure that the Serious Case Review process is supported.
- write to the RSCB Chair if, during the course of the review, it becomes clear that timescales cannot be met.
- receive the Overview Report, referring to the guidance in *the South Yorkshire Child Protection Procedures* and, *Part 1 – Practice Guidance on Serious Case Reviews*, page 5, of this document.
- consult with the RSCB Chair and recommend the final draft of the Overview Report to them for acceptance.
- respond to any questions arising when the Overview Report is presented to RSCB and makes any changes agreed at this meeting.
- ensure that an agreed Executive Summary is developed from the completed Overview Report by the Rotherham Children and Young People's Services Communications Manager .
- ensure that the family is informed of the report.
- be involved, if necessary, in any press conference or other media activity following the publication of the Executive Summary.
- lead a multi-agency debrief session open to all staff involved with the family during the period covered by the Serious Case Review.
- with the Overview Panel, review agency and RSCB action plans to ensure that they are rigorous and fit for purpose.

(See *Overview Panel*, page 25).

## 2.8 Independent Management Review Author

The Serious Case Review Panel initially determines the agencies contributing to a Serious Case Review, although additional involvement may be identified as the review progresses.

The Senior Designated Manager from each contributing agency commissions their Investigating Manager, who should not have been concerned directly with the child or family. It is the intention of the RSCB that there will be a briefing session for Investigating Managers in all Serious Case Reviews at the start of that review.

The Independent Management Review Author should

- in conjunction with the Senior Designated Manager, determine the interview strategy for their agency and the methods to be used.
- complete their agency's chronology using the standard form according to the guidance documents (see *Chronology Format and Guidelines*, page 52)
- maintain awareness of timescales and alert the Senior Designated Manager and the RSCB Business Manager to any difficulties as soon as these are identified.
- pass the completed chronology to the Senior Designated Manager to be checked.
- send the completed chronology to the RSCB Manager in electronic format (protected by the case password) by the due date unless otherwise agreed.
- identify staff to be interviewed during the review and carry out interviews.
- write the individual management report using the standard form according to the guidance documents (see *Independent Management Review Template* page 45). A form customised for the case will be supplied by the RSCB Manager.
- provide the finished report to the Senior Designated Manager to be checked, quality assured and signed off.
- send the completed management report to the RSCB Manager in electronic format (protected by the case password) by the due date unless otherwise agreed.
- send the signed hard copy of the management report to the RSCB Manager.
- make a list of all staff identified as having significant involvement in the case during the period covered by the review, should be invited to the multi-agency debrief session following the publication of the Executive Summary. This should be passed to the Senior Designated Manager and to the RSCB Manager.

**Please remember to ensure that all documents show the name of the agency clearly and any revision dates.**

## 2.9 RSCB Manager

### ***Deciding whether a Serious Case Review is needed***

The RSCB Manager will :

- establish a date for the Serious Case Review Panel to meet as soon as a case has been referred for consideration. A minimum of four members of the Sub-group must be present for the meeting to be quorate. **This meeting must take place within three weeks of the date of initial referral of the RSCB Manager being notified of the death/serious incident.**
- ask Safeguarding Board members to carry out an initial check within their organisation of records relating to the potential subject of the review prior to this meeting.
- attend and arrange administrative support to minute the meeting of the Standing Serious Case Review Panel and Overview Panel.
- ensure that a password is chosen for the case.
- distribute the minutes urgently so that the Chair of RSCB is informed of the Panel's recommendation.

### ***Once a Serious Case Review has been confirmed***

When the RSCB Chair has confirmed that a Serious Case Review is to be undertaken, the RSCB Manager:

- customises the documents required for information gathering — timescales (see *Serious Case Review Timescale Guide*, page \_ – this is available as a self calculating Excel Sheet), chronology form, management review format.
- prepares a Genogram (see 3.8 - *Example of Genogram*, page 54) to be included within the management review format, as well as to be circulated to the Overview Panel.
- prepares a letter from the RSCB chair to the Designated Senior Managers of all agencies (see *Letter informing RSCB agencies that a Serious Case Review is to be undertaken*, page 42 for details of content and accompanying documents).
- prepares a similar letter for other organisations identified by the Serious Case Review Panel as to be asked to complete management reports
- informs CYPSC Communications Manager that a Serious Case Review is to take place (in case of media interest and so that this can be monitored).
- prepares a letter to Ofsted and passes this to the Chair for signature.
- prepares letters to the CPS and Coroner where the case involves criminal proceedings or a death, liaising with the Police as necessary (see *Letter*

*informing the Coroner that a Serious Case Review is to be undertaken*, page 44).

- starts a file for the case, preparing a File Front Sheet (see *Serious Case Review File Front Sheet*, page 57) and SCR Overview (see *Rotherham LSCB -Serious Case Review Overview*, page 58) and customising these appropriately to the case. These are key tracking documents that provide an overview of what is happening on a particular case and should be kept up to date at all times. They can also be printed off prior to meetings with Ofsted to provide an up to the minute report for the RSCB Chair, though a further brief summary of what has been happening may be needed.
- act as a central point of information for everyone involved in the Serious Case Review.
- chase responses as necessary.
- arrange a briefing session for Independent Management Review Authors.

### ***Overview Panel meetings***

The RSCB Manager will:

- arrange the first panel meeting urgently (as soon as panel members have been identified) to ratify the scope and terms of reference for the review and agree a work schedule (including dates for meetings) and arrange to have minutes taken for this meeting.
- arrange subsequent meetings according to a schedule agreed at this initial meeting.
- draw up a draft calendar and work plan.
- circulate panel membership, meeting dates and schedule to all contributing agencies.
- circulate all documents to the panel (protected with the agreed password).

The RSCB Manager should attend and arrange to have minutes for subsequent meetings of the Overview Panel. The RSCB Manager may also circulate notes/action points from the Overview Panel meetings. There may also be a need to follow up issues identified within the Panel meetings.

**NB** For the purposes of the panel, it is useful to retain the full names of staff involved in the case. However, the Integrated Chronology will need to be sent to Ofsted with the Overview Report. For this purpose, names should be coded, with a key for future identification.

## ***Agency Chronologies***

The RSCB Manager should:

- log receipt and merging of chronologies for the Serious Case Review Overview Report (see - *Rotherham Serious Case Review Overview*, page 58).
- monitor progress against timescales, alerting the Chair of the Overview Panel to any problems.
- where necessary, chase outstanding chronologies.
- merge the chronologies ready for the second meeting of the Overview Panel and send these out (password protected) in advance to Panel members.

## ***Agency Management Reviews***

The RSCB Manager should

- log receipt of both electronic and signed hard copies of Individual Management Reviews on the *Serious Case Review Overview* (see *Rotherham Serious Case Review Overview*, page 58).
- monitor progress against timescales, alerting the Chair of the Overview Panel to any problems.
- where necessary, chase outstanding management reviews.
- update CYPSC Communications Manager as to likely completion date for the review.

## ***Overview Report & Executive Summary***

The RSCB Manager should:

- continue to liaise with and support the Overview Author as they complete the draft of the Overview Report – this may involve chasing outstanding information, re-scheduling meetings, etc.
- in consultation with the RSCB Chair, schedule consideration of the Overview Report at an RSCB meeting or call a special meeting for this purpose, depending on timing.
- circulate electronically a confidential copy of the draft Overview Report to all RSCB members and anyone else identified by the RSCB Chair who should receive it (via the secure on-line portal)
- pass a copy of the report to the CYPSC Communications Manager as soon as the Chair of the Overview Panel/RSCB Chair have cleared this.

When the Overview Report has been considered and agreed by the RSCB, the RSCB Manager should:

- send copies of the Overview Report, all Management Reports, the Integrated Chronology and the Executive Summary to Ofsted and the DfCSF Children's Safeguarding Unit (CSU) as directed by the RSCB Chair.
- send the Overview Report and Executive Summary to others, including CEOs from key agencies as required. The RSCB Chair should provide guidance on this.
- make a copy of the Executive Summary available on the RSCB web site as soon as it is published (convert to a pdf) and publicise this via the RSCB E-zine or by e-mail as required.
- liaise with the RSCB Chair and Chair of the Overview Panel as to an appropriate date for a 'Multi-agency Debrief Meeting'.
- organise the 'Multi-agency Debrief Meeting' and circulate information to staff identified by the Designated Senior Managers as directly involved in the case.

### ***Media Activity***

The RSCB Manager may also be asked to support media activity and monitoring prior to, and following, the publication of the Executive Summary.

- all press releases should be circulated to RSCB members.
- copies of all press releases and coverage should be filed in the Serious Case Review Media Coverage file.

### ***Action Plans***

The RSCB Manager will

- on behalf of the RSCB Chair, send out a request to agencies involved in the review to complete an action plan, together with the appropriate form, guide, due date and details of recommendations. RSCB members will have a copy of the Overview Report; other agencies may only have the Executive Summary.
- monitor and chase return of action plans, logging progress on the *Serious Case Review Overview* (see - *Rotherham - Serious Case Review Overview*, page 58).
- take the RSCB action plan to the next SCR Standing Panel meeting for completion.
- liaise with the Chair of the Overview Panel to arrange a meeting for the panel to review action plans to ensure that they are fit for purpose.
- forward all action plans to the members of the Overview Panel in preparation for this meeting.

- take the agreed RSCB Action Plan to the next full RSCB Meeting for formal adoption.
- send a copy of the agreed RSCB Action Plan to Ofsted.
- schedule update sessions at appropriate SCR Standing Panels and request updates accordingly. Any concerns identified at these meetings should be taken to a full Board meeting.
- request and collate information on positive outcomes for children and families in Rotherham and for multi-agency staff as a result of actions taken following a Serious Case Review.
- combine updated information into a single document for presentation at Practice Standards Sub-Committee.
- ensure that, once agencies report that all actions have been completed, a hard copy of their updated action plan, duly signed off by the Designated Senior Manager, is held on file as well as an electronic copy of the completed plan.
- using the completed agency and RSCB action plans, draw together a final master document as a permanent record of all actions taken as a result of the Serious Case Review. This document should be formally 'signed off' by the RSCB Chair on behalf of the RSCB.

### ***RSCB Annual Report and Business Plan***

Whilst preparing the Annual Report and Business Plan, the RSCB Manager should:

- consider how best to report on any Serious Case Reviews undertaken during the year, if necessary looking at common themes. This should particularly focus on positive outcomes for children and families in Rotherham and for multi-agency staff as a result of actions taken following a Serious Case Review
- ensure that any outstanding RSCB actions arising from Serious Case Review are reflected fully within the Business Plan.

## **2.10 Rotherham Safeguarding Children Board**

On receipt of the Overview Report, it is the responsibility of the RSCB to

- ensure that contributing agencies and individuals are satisfied that their information is fully and fairly represented.
- accept, following any agreed amendments, the Overview Report and Executive Summary.
- consider how to deal with public relations issues/media interest.
- help disseminate the key findings.
- through sub-group, develop the RSCB Action Plan in response to the recommendations contained in the Overview Report.
- review the RSCB Action plan developed in response to the Overview Report prior to adopting it.
- with the RSCB Chair, monitor the progress of agency action plans, primarily through the Management Group.
- review information received from agencies as to positive outcomes for children and families in Rotherham and for multi-agency staff as a result of actions taken following a Serious Case Review.
- audit actions against recommendations and intended outcomes.

### Part 3 - Serious Case Review Documents

<b>Part 3 - Serious Case Review Documents</b>	
Serious Case Review Timescale Guide	
Template for Terms of Reference	
Chronology Format and Guidelines	
Management Review Format	
What is Required	
Conduct of Management Review	
Summary of Chronology	
Key Issues (identifying good and poor quality practice)	
Lessons learned	
Recommendations for Own Agency	
Action Plan Format and Process	
Action Plan Format and Guidelines	
Action Plan Update Pro-forma	

### 3. 1 Serious Case Review Timescale Guide

Case: *Example*

	Date	Key Actions	Additional Actions
<b>Day 0</b>	01-Jan	Case referred by agency to <b>RSCB Manager</b> for consideration of SCR.	
<b>1 week</b>	08-Jan	<b>RSCB Manager</b> refers to SCR Standing Panel	SC Board Manager sets up meeting.
<b>End week 4</b>	29-Jan	SCR Panel makes recommendation, determines agency involvement and scope of review, recommends who will Chair the Overview Panel and agrees password. <b>RSCB Chair</b> informs Ofsted.	
<b>End week 5</b>	05-Feb	<b>RSCB Chair</b> informs all agencies & requests identification of panel members (if applicable) & investigating manager, as well as completion of reports and chronologies. Designated Senior Managers secure case records promptly. They identify an Investigating Manager to prepare their report according to timescales and guidelines provided.	Copy to Communications Manager - and CPS and Coroner where criminal proceedings or death. Family informed of SCR by worker as agreed by Chair of Overview Panel. Agency staff involved in case informed of SCR by Senior Designated Managers.
<b>End week 6</b>	12-Feb	The Board Manager arranges a series of Overview Panel meetings, liaising with the Chair of the Overview Panel. The 1st meeting will confirm the terms of reference. Subsequent meetings will review first the chronologies and the management reports.	A briefing meeting will be held by the Business Manager for Investigating Managers.
<b>End week 9</b>	07-Mar	All agency chronologies should have been e-mailed to the RSCB Business Unit. Via the RSCB Business Manager, the Chair of the Overview Panel seeks any chronologies not received.	RSCB Business Manager prepares merged chronology.
<b>End week 11</b>	18-Mar	All agency Management Reports should have been e-mailed to the RSCB Business Manager, with a signed hard-copy to follow. Via the RSCB Business Manager, the Chair of the Overview Panel seeks any Management Reports not received.	The Senior Designated Manager agrees/signs off the Management Report on behalf of their agency.
<b>End week 14</b>	08-Apr	Overview Panel agrees draft of Overview Report and 1st draft of	

		Overview Report to <b>RSCB Chair</b> .	
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**Case:** *Example*

	Date	Key Actions	Additional Actions
<b>End week 20</b>	20-May	<b>RSCB Chair</b> takes draft Overview Report and action plan to RSCB for agreement.	Special RSCB meeting called if necessary.
<b>End week 22</b>	03-Jun	Executive Summary urgently extracted from the Overview Report and circulated to RSCB for final approval.  Final report sent by Overview Panel Chair to <b>RSCB Chair</b> and circulated to RSCB Members.  Overview Report, Executive Summary, Integrated Chronology, Individual Management Review Reports and Action Plans to Ofsted. Overview Report and Executive Summary to DCSF Safeguarding Unit. <b>RSCB Chair</b> requests agency Action Plans (via RSCB Manager).	Executive Summary shared with the family, usually by the same person as informed them of the review (see week 5) RSCB Agencies debrief their own staff.
<b>End week 28</b>	15-Jul	Overview Panel meets to quality assure agency & RSCB Action Plans.  Overview Panel Chair, with support from other Panel member(s), holds multi-agency debrief.	
<b>End week 40</b>	07-Oct	RSCB Standing SCR Panel checks progress of Action Plans, reporting to RSCB. This process is continued until all actions have been completed, with any concerns or barriers to completion being referred to the RSCB.	Positive outcomes for children and families and for multi-agency staff resulting from the actions taken in response to the SCR are recorded.
<b>RSCB Chair</b> signs off SCR.			

### 3.2 Draft Template for Terms of Reference for Serious Case Reviews:

1. Outline the reason for the review and the most important issues to address at the outset in trying to learn from this specific case and how the relevant information can best be obtained and analysed.
2. Identify the independent author to be appointed for the overview report or the process and timescale to appoint the author.
3. Indicate whether there are features of the case that indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals/organisations who will be required to participate in the review.
4. Indicate whether it might help the Review Panel to bring in an outside expert at any stage, to shed light on crucial aspects of the case.
5. Set out the time period enquiries cover (beginning and ending)
6. Set out the family history/background information which will help better to understand the recent past and present
7. Outline which organisations and professionals should contribute to the review through individual management reviews, other reports or alternative methods
8. Outline any consent issues and also proposals for the contribution of family members to the review, and who should be responsible for facilitating their involvement.
9. Identify whether the case will give rise to other parallel investigations of practice and/or review processes.

Independent health investigations	Multi-disciplinary	suicide
	reviews	
Homicide review where a parent has been murdered	YJB	Serious Incident
Prisons and Probation Ombudsman investigation where the child has died in a custodial setting	Review	
Other (Set out details)		

10. Outline arrangements to ensure that a co-ordinated or jointly commissioned review process addresses all the relevant questions that need to be asked, in the most economical way.
11. Indicate whether there is a need to involve organisations/professionals in other LSCB areas and if necessary, the respective roles and responsibilities of the different LSCBs with an interest.

12. Outline how the review process should take account of a Coroner's inquiry, and (if relevant) any criminal investigations or proceedings related to the case also arrangements for liaison with the Coroner and/or the Crown Prosecution Service?

13. Highlight any relevant interests outside the main statutory organisations – e.g. independent professionals, independent schools, voluntary organisations – with which the Safeguarding Children Unit will establish links.

14. To consider and give details of any research which adds weight to the analysis or findings.

**15. Timetable for the Serious Case Review**

Start date:

Completion date for Individual Agency Management

Reviews:

Date to review Individual Agency Management Reviews:

Provisional date for completion of Overview Report

Date to consider Overview Report

Production of final Overview Report, joint action plan and Executive Summary

Publication of Executive Summary (after OFSTED evaluation)

Completion of plan of actions from recommendations

16. Outline how public, family and media interest will be managed before, during and after the review.

17. Identify whether RSCB needs to obtain independent legal advice about any aspect of the proposed review.

18. Agencies should complete their Individual Management Review to the agreed format (attached):

These terms of reference have been approved by Rotherham Safeguarding Children Board.

Signature of Chair: ..... Date: .....

**3.3. Notification letter of Serious Case Review to parents/carers**

Logo

**Rotherham Metropolitan  
Borough Council  
Strategic Safeguarding Children  
Unit  
2<sup>nd</sup> Floor, Crinoline House  
Effingham Square  
Rotherham  
S65 1AW**

**PRIVATE & CONFIDENTIAL**

Date: **XXXXXXXX**

Dear **XXXXXXXXXXXX**,

I am writing to you following the very sad death of your **son/daughter** in **Month, Year** **or serious incident/circumstances** requiring a Serious Case Review.

The Rotherham Safeguarding Children Board has made a decision to undertake a Serious Case Review considering the work of professionals and agencies who may have offered your family a service.

The Safeguarding Children Board consists of a number of senior professionals from different agencies in Rotherham who provide services or are responsible for working with vulnerable children and their families.

A Serious Case Review has to be undertaken when a child has died and there is any concern about the level of care they received. The Board has a duty to appoint a panel of senior people from agencies including Children’s Social Care, Health and Police to review what happened in the work they did or did not undertake with your family to see if there are lessons to be learned to prevent deaths in the future.

You will be invited to give your views to this panel, most probably at interview with one or two people. You may give your views in writing if that’s what you prefer. You

can, of course, have someone with you to support you when you are interviewed if you wish.

The Panel gathers information from a number of sources and considers a report written by an independent person . A summary of this report is published in a way that does not include any names so that your family's identity should not be recognised. Wherever possible a copy of this summary will be made available to you. You will be notified in advance of the publication of this summary.

If you have any concerns about the Serious Case Review process or want any questions answered please contact **XXXXXXXXXX** on 01709 **XXXXXX**, or ask someone to call for you.

Yours sincerely

**XXXXXXXXXX**

Chair  
Rotherham Safeguarding Children Board

### 3.4 Notification letter of Serious Case Review to Senior Designated Managers

Rotherham Metropolitan Borough Council  
 Strategic Safeguarding Children Unit  
 2<sup>nd</sup> Floor, Crinoline House  
 Effingham Square  
 Rotherham  
 S65 1AW

Date: XXXXXXXX

Dear Colleague

**TITLE: Serious Case Review following the death of a child/serious incident**

Name of child: XXXXXXXXXXXXXXXX

Date of birth: DD/MM/YYYY

Date of death: DD/MM/YYYY

Address(es): XXXXXXXXXXXXXXXXXXXX

Significant Others

<u>Relationship to child</u>	<u>Name</u>	<u>DOB</u>	<u>Ethnicity</u>	<u>Address</u>

I am writing to inform you of the decision of the Chair of the Rotherham Safeguarding Children Board to hold a Serious Case Review on the above named child. The process for such a review is set out in *Working Together to Safeguard Children 2006* and Rotherham’s Child Protection Procedures. I should be grateful if you could ensure that records held by your agency in respect of all family members are checked and secured.

Should you identify that your agency had involvement, you will need to appoint an author, independent from the direct work to undertake an Individual Management Review (IMR). These reviews are the responsibility of single agencies and are of the utmost importance in meeting statutory requirements around the protection of children. I should be grateful if you would inform me of the name of the author.

Would you please confirm formally to me if your agency is to undertake a review or has no involvement with this family by DD/MM/YYYY.

Draft terms of reference for this review will be presented at a scoping meeting at the earliest opportunity and these, along with relevant templates for reviews and guidance notes will be forwarded to you as soon as possible after that date.

As set out in my previous letter please check your records for any involvement and appoint an author for the Internal Management Review. Please confirm to me if your agency had no involvement.

If you, IMR authors or any other colleagues have any questions or require support or advice about this process please contact me.

Yours sincerely

XXXXXXXXXX

Rotherham Safeguarding Board Manager

**3.5 Notification letter of Serious Case Review to Coroner**

**Rotherham Metropolitan Borough Council  
Strategic Safeguarding Children Unit  
2<sup>nd</sup> Floor, Crinoline House  
Effingham Square  
Rotherham  
S65 1AW**

Date: XXXXXXXX

Dear XXXXXXXX

**TITLE: Serious Case Review following the death of a child**

Name of child: XXXXXXXXXXXXXXXX

Date of birth: DD/MM/YYYY

Date of death: DD/MM/YYYY

Address: XXXXXXXXXXXXXXXXXXXX

I am writing to inform you that the Rotherham Safeguarding Children Board Serious Case Review Panel has considered the death of the above child and made a recommendation to the Chair that a Serious Case Review should be held in accordance with the guidance set out in *Working Together to Safeguard Children 2006* and Rotherham’s Child Protection Procedures. The recommendation has been ratified by the Chair of the Rotherham Safeguarding Children Board.

If there is any further information you require, please do not hesitate to contact me.

Yours sincerely

XXXXXXXXXX  
Rotherham Safeguarding Board Manager

**3.6 STANDARD TEMPLATE and GUIDANCE FOR COMPLETING MANAGEMENT REPORTS**



CONFIDENTIAL

INDIVIDUAL MANAGEMENT REVIEW  
FOR A SERIOUS CASE REVIEW

COMMISSIONED BY  
ROTHERHAM SAFEGUARDING CHILDREN  
BOARD

IN RESPECT OF

Subject:

DoB:

**Author:** (Name and Designation)                      **Date:**

**Countersigned:**(Name and Designation) **Date:**

## TABLE OF CONTENTS

<b>SECTION 1</b>	<b>Introduction</b>
	<b>Terms of Reference</b>
	<b>The IMR Author</b>
	<b>Process of this Review</b>
	<b>Family Composition/Genogram</b>
<b>SECTION 2</b>	<b>Agency involvement with this child and family</b>
<b>SECTION 3</b>	<b>Analysis of Involvement</b>
<b>SECTION 4</b>	<b>Learning from this case</b>
<b>SECTION 5</b>	<b>Recommendations for Action</b>
<b>SECTION 6</b>	<b>Action Plan (using template) – Following completion and acceptance of the Overview Report</b>
<b>APPENDIX 1</b>	<b>Comprehensive Chronology using template Index of family members and staff involved.</b>

## **GUIDANCE NOTES for IMR Authors**

### **SECTION 1: INTRODUCTION**

#### **Introduction/Reason for the Report** (for example)

This individual management review of (*NAME OF ORGANISATION*) is produced in accordance with Rotherham Safeguarding Children Board procedures for conducting a Serious Case Review. Information from this Individual Management Review will be used to inform a Serious Case Review overview report as recorded in *Working Together to Safeguard Children 2006*.

#### **Terms of Reference**

Refer to the original letter and include key details from the Terms of Reference document

The Terms of Reference for the Report are based on Working Together 2006 (8.21 – 8.27). All Management Reports must address the following (an outline repeated in each section of the report template).

#### **The IMR Author**

Brief description emphasizing independence from the case

#### **Process of this Review**

This report has been prepared following a review of the care/services provided to the child/family, with the aim of looking openly and critically at individual and agency 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 (*Working Together 2006 – 8.22*).

The following sources of information regarding (*NAME OF SUBJECT(S)*) have been used to inform the report:

#### **Examples**

- a. Chronology compiled from Child Health/Patient Records (eg Health Visiting records/School Nursing records/Hospital Notes)
- b. Consultation notes made by named child protection professionals
- c. General Practitioner notes
- d. School Records
- e. School Attendance Service Records
- f. Social Worker Records
- g. Child Protection Conference minutes
  
- h. Interviews with: (*JOB TITLE – NOT THE NAME OF THE PERSON*)

## **Family Composition and Genogram**

### **Subject:**

Name:

Gender:

DoB:

(DoD if applicable):

Address:

### **FAMILY COMPOSITION**

(For example)

Mother:

DoB:

Address:

Father:

DoB:

Address:

Full Sibling:

DoB:

Address:

Half Sibling:

DoB:

Address:

### **Other Addresses on File:**

### **Other Household Members/Significant Others:**

Name:

DoB:

### **Other Addresses for family members over the period of the Review Include Genogram**

## **SECTION 2: AGENCY INVOLVEMENT WITH THIS CHILD AND FAMILY**

- What was our involvement with this child and family?
- Construct a comprehensive chronology (using the template provided above) of involvement by the organisation and/or professional(s) in contact with the child and family over the period of time set out in the review's terms of reference.
- Briefly summarise decisions reached, the services offered and/or provided to the child(ren) and family, and other action taken.

## **SECTION 3: ANALYSIS OF INVOLVEMENT**

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. Consider specifically:

- Consider the events that occurred, the decisions made, and the actions taken or inaction.
- Provide your understanding not only of what happened but why
- Indicate whether the judgements made, or actions taken, indicate that practice or management could be improved.
- Consider specifically whether practitioners were 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
- 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 actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments? Were the assessments/actions completed within timescales and of sufficient quality?
- Where relevant, were appropriate child protection or care plans in place, and was there compliance with child protection and/or looked after reviewing processes and was the core group and child protection conference(s) effective?

- When, and in what way, were the child(ren)'s wishes and feelings ascertained and considered? Was this information recorded?
- Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?
- 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 RSCB policy and procedures for safeguarding children, and wider professional standards?
- Interagency working and communication between agencies involved.
- Were there any similarities with previous Serious Case Review recommendations and subsequent actions?
- Was there any discussion around threshold for legal action in respect of children?
- Was the management, supervision and support of staff involved with child protection cases appropriate to their level of experience and knowledge?

#### **SECTION 4: WHAT CAN BE LEARNT 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; training (single and interagency); management and supervision; working in partnership with other agencies; resources?

#### **SECTION 5: RECOMMENDATIONS FOR ACTIONS**

Recommendations should be 'SMART' – Specific, Measurable, Achievable, Realistic & Timely.

- What action should be taken by whom, and by when?
- What outcomes should these actions bring about?

- What are the likely resource implications of these actions being carried out?
- How will the organisation evaluate whether they have been achieved?

Using the outline action plan template, list the agency's recommendations and complete the action plan as far as possible.

NB A further action plan may be required in response to recommendations in the Independent Overview Report.

**SECTION 6: OUTLINE ACTION PLAN**

**Child:**

**Agency:**

Recommendation		
Action	Responsible Individual	Target date
Evidence/Progress		Date of Update:

### 3.7 Chronology Format and Guidelines

Please refer to Part 1 – Practice Guidance on Serious Case Reviews, Single Agency Management Reviews (page 8) and to Part 2 – Actions By Role, (page 13).

#### Chronology for: Agency

Date	Family Member (s)	Event/ Information (include those present)	Agency (Source of Information)	Action Taken/other agency response	Child seen (any views and wishes noted)	Note

Investigating managers will be provided with an electronic version of this template (which is in landscape format). Consistent initials for family members will be agreed at the briefing meeting for Investigating Managers convened by the Safeguarding Board Manager.

When completing the chronology, authors may find it helpful to be aware that it will be merged into an INTEGRATED CHRONOLOGY. **All data must include full details for each line and be identifiable in the final document.** Facts should be recorded as they became known to your agency, not as they occurred (e.g. ‘we were informed on 1 September that the family had moved on 12 June’ – entry dated 1 September, NOT 12 June)

**Family Members (Subject(s) of entry)** – The person who is the subject of the entry - please use initials as indicated in the Genogram (see the customised Management Review format), e.g. JB for Jill Brown, AB for Andrew Brown, etc. This may be the main subject of the Serious Case Review, a sibling, parent, etc. and should be entered for every row in the table (to identify information in the integrated chronology)

**Date** –Date of event recorded. Please use the format dd/mm/yy, e.g. 12/11/04. Please put an entry in this column, even if it is something like ‘June 04 approx’

**Time** – Where an exact time is noted, please give this in the 24 hr format, e.g. 14:20. If you know the time of day, please indicate am or pm. If you do not have a record of the time, please leave blank.

**Agency** – Your agency/service – please note this at the top of the front sheet of your chronology and in the ‘Agency’ column for every line so that your information remains identifiable when the chronologies are merged. You may wish to add further detail within this column, such as a particular part of your service or the names of staff (see Note 4, below).

**Event/information** – e.g. (home or office) visit, letter, telephone call and by whom to whom. Include summary information.

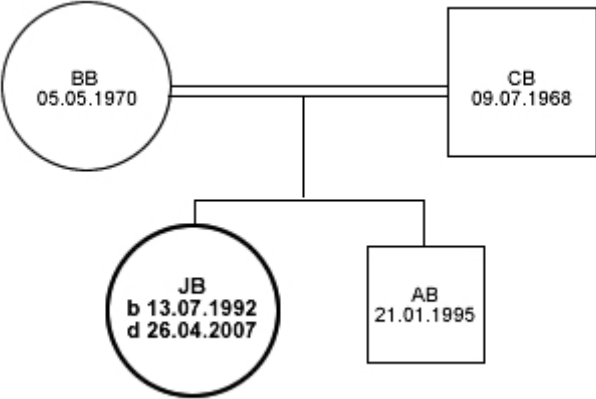
**Action Taken** – The action taken, e.g. referral to another agency and by whom

**Child seen (any views and wishes noted)**– please use initials as in subject or N/K for ‘not known’ or N/I for ‘not indicated’.

**Additional Guidance points for those completing the chronology:**

1. The table has been made as large as possible. The pro-forma has been designed with both left and right margins set to 1.5 cm – you may find you need to re-set this on your machine due to the way Word treats documents prepared elsewhere.
2. Please add extra rows to the grid as necessary (Table, Insert, Rows), but do not add blank rows between entries.
3. Please remember that family names should be suitably anonymised throughout (e.g. JB for Jill Brown, AB for Andrew Brown, etc.).
4. Please give the role, name and initials of all professionals involved- they will be anonymised in the final versions of IMRs submitted to Ofsted and in the Overview Report.
5. Please password-protect the file (Tools, Options, Save) with the password agreed for the specific Serious Case Review (if in doubt, please check!).
6. Please provide a key for any acronyms used in your Chronology/Management Reports.
7. Please send reports commissioned from third-party reviewers to the commissioning agency before passing them to the RSCB Manager.

**3.8 Example of Genogram**  
**Serious Case Review: Jill Brown, dob 13-07-1992)**



## Letter to Ofsted to accompany Overview Report

Rotherham Metropolitan Borough Council  
Strategic Safeguarding Children Unit  
2<sup>nd</sup> Floor, Crinoline House  
Effingham Square  
Rotherham  
S65 1AW

### PRIVATE & CONFIDENTIAL

Contact Name  
Ofsted National Business Unit  
Royal Exchange Buildings  
St Ann's Square  
Manchester  
M2 7LA

Date: XXXXXXXX

Dear XXXXXXXXXXXX,

**Re: Serious Case Review Overview Report in respect of XX**

Please find enclosed the Overview Report in respect of XX, together with the Executive Summary, the Integrated Chronology, Composite Action Plan, and Individual Management Reports.

If you require any further information, please do not hesitate to contact me.

Yours sincerely

XXXXXXXXXX

Chair  
Rotherham Safeguarding Children Board

**Rotherham Safeguarding Children Board  
 Serious Case Review Action Record**

**Child:**  
**Agency:**

Recommendation		
Action	Responsible Individual	Target date
Evidence/Progress 1.		Date of Update:
Evidence/Progress 1.		Date of Update:
Evidence/Progress 1.		Date of Update:
Evidence/Progress 1.		Date of Update:

# Serious Case Review File Front Sheet

## ROTHERHAM RSCB

### SERIOUS CASE REVIEW FILE FRONT SHEET

Name of Case:

Action	Date
Critical Incident	
Critical Incident Form to Ofsted	
<b>Overview Panel Members:</b>	
<b>Chair of Overview Panel:</b>	
<b>Author of Overview Report:</b>	

Chronologies & Management Reports		
Integrated Chronology Completed (Date)	Integrated Chronology to Ofsted (Date)	Management Reports to Ofsted (Date)

Report					
Draft Considered by Overview Panel (Date)	Report to LSCB Meeting (Date)	Final Report Circulated to LSCB Members (Date)	Executive Summary Approved by LSCB (Date)	Report & Executive Summary to Ofsted (Date)	Report & Executive Summary to CSU (Date)

Action Plans				
LSCB Action Plan Drawn Up by Management Group (Date)	To Overview Panel Meeting (Date)	Action Plans Signed Off as Fully Complete by LSCB Chair (Date)	Action Plans Circulated to LSCB (Date)	Action Plans to Ofsted (Date)

# Rotherham RSCB -Serious Case Review Overview

CASE: (Initials)

	Management Reports				Chronology		Action Plans			
	Date of letter requesting Management Report & Chronology date		Management Reports Circulated (Date):	date			Date of letter requesting Plans:	letter Action	date	
	Requested by (Date):				Integrated Chronology Circulated (Date):		Requested (date)	by	date	
AGENCY	AUTHOR – Who Will complete your management report? (To be confirmed by date)	How will they complete this (e.g. file reading, interviews, etc.)	Report Promised / Received Date (Electronic)	Signed Off By	Signed Copy Received	Agency Chronologies Promised / Received Date	Added to Integrated Chronology (Date)	Promised / Received (Date)	Updated Action Plan Promised / Received (Date)	Updated Action Plan Promised / Received (Date)
CAFCASS										
Children & Young People's :										
Locality Services										
Targeted Services										
Inclusion										
YOT										
Neighbourhood										

and Adult Services									
S&M NHS Trust									
NHS Rotherham									
Community Paediatrics / Child Health									
GP Service									
Health Visiting Service									
School Nursing									
Speech & Language Therapy Services									
Ambulance Service									
South Yorkshire Police									
National Probation Services									

## Appendix . Ofsted Descriptors for the Evaluation of Serious Case Reviews

Judgement	Descriptors
<p><b>Outstanding</b>  <b>The review was very well managed, outcome focussed and promotes a culture of learning. It fully addresses the terms of reference and requirements of Chapter 8 of Working Together.</b></p>	<p>The scope of the review is unambiguous, outcome focussed and supported by clear terms of reference which ensure that all relevant information can be obtained and analysed within the agreed time scale. The contribution of all relevant agencies is secured. A high level of independence is built into the process including the appointment of an independent author of the overview report and access to expert advice on critical or complex aspects of the case. Arrangements to involve relevant family members are effective. All other parallel investigations including criminal investigations and coroner's enquiries are considered and where appropriate, effective communication processes or jointly commissioned review arrangements have been agreed. Contingency arrangements help to ensure timely responses to new information or changes during the process of the review. Any delays in completion of the report within four months are unavoidable and have not delayed implementation of identified actions for improving practice. The review is completed within an agreed time scale.</p> <p>All relevant agencies produce a comprehensive and well-structured management review of their full involvement with the child(ren) and family. The review takes full account of the outcomes for the child(ren) concerned in light of their individual needs and their racial, cultural, linguistic and religious identity. Practice at individual and organisational levels is analysed openly and critically against national and local statutory requirements, professional standards and current procedural guidance. Good practice is highlighted. Areas for changes in practice are clearly identified and supported with measurable and specific recommendations for improvement.</p> <p>The overview report coherently brings together the findings of all individual management reviews and other relevant investigations, reviews or enquiries. It summarises the facts of the case succinctly including a clear genogram and a comprehensive and well-organised chronology which maintain a clear focus on the child(ren) concerned throughout. Outcomes for the child(ren) are considered against all the information known to the agencies and professionals concerned about the parents, child and perpetrators, the family history and home circumstances. The report is based upon a critical analysis of the facts and a strong evaluation leading to convincing conclusions for how and why events occurred and actions or decisions by agencies were or were not taken. The benefits of hindsight and evidence from</p>

	<p>research are used deftly by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events. Lessons to be learned, nationally and locally, are specific and supported by achievable recommendations for improving practice and a comprehensive action plan for implementation. The action plan is underpinned by a clear process for monitoring and evaluation of its implementation and impact.</p> <p>An executive summary is completed and includes succinct information about the review process, practice issues arising from the case and recommendations which have been made. Secure arrangements are in place for the publication of the executive summary. The executive summary includes a synthesis of the lessons learned and it written in a style that is accessible to a wide range of readers and is jargon free.</p>
<p><b>Good</b>  <b>The review fully addresses the terms of reference and requirements of Chapter 8 of Working Together. It identifies relevant lessons for improving practice.</b></p>	<p>The scope of the review is unambiguous, outcome focussed and supported by clear terms of reference which ensure that nearly all relevant information can be obtained and analysed. The contribution of all relevant agencies is secured. Independence is built into the process including the appointment of an independent author of the overview report and access to legal advice on critical aspects of the case. The contributions of relevant agencies are clearly defined and clear arrangements have been put in place to secure the involvement of relevant family members. Other parallel investigations including criminal investigations and coroner’s enquiries are considered and where appropriate effective communication processes are in place. Any delays in completion of the review are unavoidable and it is completed broadly in line with an agreed time scale</p> <p>Relevant agencies produce a comprehensive management review of their full involvement with the child and family. Any gaps in information are minor and do not impact directly on the outcome for the child(ren) concerned. The review takes into account the individual needs of the child or children and is sensitive to their racial, cultural, linguistic and religious identity. Practice at individual and organisational levels is analysed openly and critically against national and local statutory requirements, professional standards and current procedural guidance. Good practice is highlighted. Areas for changes in practice are clearly identified and supported with measurable and relevant recommendations for improvement.</p> <p>The overview report coherently brings together the findings of the individual management reviews and other relevant investigations, reviews or enquiries. It sets out the facts of the case logically and includes a clear genogram and a comprehensive chronology of events relating to the history of the child and family and agency involvement Outcomes</p>

	<p>for the child(ren) are considered against the available information known to the agencies and professionals concerned about the parents, carers and perpetrators, the family history and home circumstances The report reflects a critical examination of the facts and provides credible explanations for how and why events occurred and actions or decisions by agencies were or were not taken. The benefit of hindsight is used appropriately by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events. Lessons to be learned, nationally and locally, are clearly identified and supported by specific and achievable recommendations for improving practice and a comprehensive action plan for their implementation.</p> <p>An executive summary is completed and includes succinct information about the review process, key issues arising from the case and recommendations which have been made. Secure arrangements are in place for the publication of the executive summary.</p>
<p><b>Adequate The review does not fully address the terms of reference or meet the full requirements of Chapter 8 of Working Together. However this</b></p>	<p>The scope of the review is defined and supported by terms of reference which support the collation of the relevant information for the review. Independence is built into the process through the appointment of an independent author of the overview report and access to legal advice on critical aspects of the case. The relevant agencies are identified and arrangements have been put in place for the involvement of relevant family members. Other parallel investigations including criminal investigations and coroner’s enquiries are considered and where appropriate, communication processes are agreed. Where there are delays in the completion of management reviews and the overview report, these are explained and do not significantly impede timely dissemination of the lessons learned.</p> <p>Most relevant agencies produce individual management reviews of their involvement with the child and family. Most reviews take into account the individual needs of the child and family and record their racial, cultural, linguistic and religious identity. Practice is analysed by most agencies openly and critically against national and local statutory requirements, professional standards and current procedural guidance. Gaps in information are identified and</p>

<p><b>shortfall does not impact adversely on the outcome of the review in identifying the relevant lessons to be learned.</b></p>	<p>explained. Areas for changes in practice are mostly identified and supported with measurable and relevant recommendations for improving practice..</p> <p>The overview report brings together the findings of all reports from agencies and other relevant investigations, reviews or enquiries. It sets out the facts of the case logically and includes a genogram and a chronology of the family history, circumstances of the child and agency involvement. Reference is made to what information was known to the agencies and professionals concerned about the parents, carers and perpetrators, the family history and home circumstances of the child. The report includes examination of the key facts and provides credible explanations for any gaps in information, how and why events occurred and actions or decisions by agencies were or were not taken. The benefit of hindsight is used appropriately by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events. Lessons to be learned, nationally and locally, are identified and supported by specific and measurable recommendations for improvement and a relevant action plan for their implementation.</p> <p>An executive summary is completed and includes relevant information about the review process, key issues arising from the case and recommendations which have been made. Secure arrangements are in place for the publication of the executive summary.</p>
<p><b>Inadequate The review does not fully address the</b></p>	<p>The scope of the review is unclear and supported by imprecise terms of reference which fail to ensure that the relevant information can be obtained and analysed. The contributions of some relevant agencies are not secured. Insufficient independence is built into the process such as the appointment of an independent author of the overview report. The involvement of relevant family members has not been agreed. Some parallel investigations including</p>

<p><b>terms of reference meet the requirements of Chapter 8 of Working Together. A lack of rigour in the management of the review impacts adversely on its capacity to ensure that lessons are identified and learned.</b></p>	<p>criminal investigations and coroner's enquiries have not been considered within the scope of the review and processes for communication are unclear. There are substantial and avoidable or unexplained delays in the completion of the review which impede timely dissemination of lessons to be learned.</p> <p>Not all relevant agencies produce a management review of their involvement with the child and family. Some reviews do not take into account the individual needs of the child and family including their racial, cultural, linguistic and religious identity. The extent to which practice at individual and organisational levels is analysed openly and critically against national and local statutory requirements, professional standards and current procedural guidance is inconsistent across agencies. There are gaps in information which are not fully explained. Some areas for changes in practice are identified but are not always supported with measurable and relevant recommendations for improvement.</p> <p>The overview report brings together most of the findings of the individual management reviews and other relevant investigations, reviews or enquiries. There are some gaps in the genogram and chronology of information relating to the family history, circumstances of the child and agency involvement which impact adversely on the coherence of the report. Reference is not always made to what information was known to the agencies and professionals concerned about the parents, carers and perpetrators, the family history and home circumstances of the child. The report lacks rigour in its examination of the facts and explanations on how and why events occurred and actions or decisions by agencies were or were not taken. The use of the benefit of hindsight by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events is not convincing. Some lessons to be learned, nationally and locally, are identified but not always supported by specific recommendations for improvement and a relevant action plan for implementation.</p> <p>An executive summary is completed but there are gaps in information about the review process, key issues arising from the case and recommendations which have been made. Arrangements for the publication of the review are not secure.</p>
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