



# **Bexley Local Safeguarding Children Board**

## **Serious Case Review**

### **Procedures & Guidance**

**August 2010**

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## **1. Introduction**

1.1 This procedure and guide for practice for undertaking Serious Case Reviews (SCR) has been prepared taking into account the statutory guidance in Chapter 8 Working Together to Safeguard Children (2010), Ofsted evaluation descriptors and the Laming Report (2009).

1.2 The purpose of the procedure is to set out the actions to be taken in respect of undertaking an SCR and guidance on practice for agencies involved.

1.3 The purpose of this document is to ensure that the process and purpose of holding a SCR is met locally and that possible lessons are acted upon quickly.

## **2. Purpose of Serious Case Review**

2.1 A SCR is undertaken when a child has died and abuse or neglect is known or suspected to be a factor in the death or a child has been seriously harmed AND the case gives rise to concern about how agencies work together. A SCR is conducted into the involvement, with the child and their family, of organisations and professionals to ensure any lessons to be learnt are identified and acted upon.

"To be effective a serious case review must include consideration of the lessons that can be learned within each of the services involved in the case, as well as how they co-operate together"  
Laming 2009

2.2 The purpose of a SCR is to:

- Establish whether there are any lessons to be learned from the case about the way in which professionals and organisations work individually and collectively to safeguard children
- Identify clearly what those lessons are, both within and between agencies, how they will be acted upon, within what timescales and what changes are required to ensure outcomes for children are improved
- To improve intra & inter-agency working to safeguard and promote the welfare of children.
- Learning from SCRs must be disseminated effectively & recommendations implemented in a timely manner

2.3 SCRs are not part of any disciplinary process but information from the SCR may indicate that an agency should consider disciplinary action within the agency's HR procedures.

2.4 SCRs are not inquiries into how a child died or who is culpable which are matters for the police, coroners & criminal courts but seek to understand the circumstances leading up to the death and the role of agencies & organisations working with the child & their family.

2.5 The SCR should be respectful to the child and the family and conducted in such a way that family members feel able to be involved and contribute to the review. This may be subject to restriction by any criminal investigation being undertaken.

2.6 The completed SCR will be evaluated by Ofsted against defined descriptors to ensure that it has been undertaken in a robust, independent & effective manner.

2.7 The Overview Report will be published by the LSCB at the end of the SCR and on completion of any criminal processes.

### **3. Criteria for Serious Case Reviews**

3.1 LSCBs are required to undertake an SCR under Regulation 5 of the LSCB Regulations 2006 if the criteria described in Working Together (8.4 & 8.11) are met. There are 2 sets of criteria for SCRs, the first is mandatory:

- When a child dies (including by suicide) and abuse or neglect is known or suspected to be a factor in the death
- In addition a SCR should be carried out if a child dies in custody, on remand or following sentencing in a Young Offenders Institution, Secure Training Centre, secure children's home or detained under the Mental Health Act 2005

3.2 The second is discretionary and states that an LSCB should always consider whether an SCR should be undertaken where:

- A child sustains a potentially life threatening injury or serious and permanent impairment of physical &/or mental health and development through abuse or neglect  
Or
- A child has been subject to a serious sexual abuse  
Or
- A parent has been murdered and a homicide review is being instigated  
Or
- A child has been killed by a parent with a mental illness

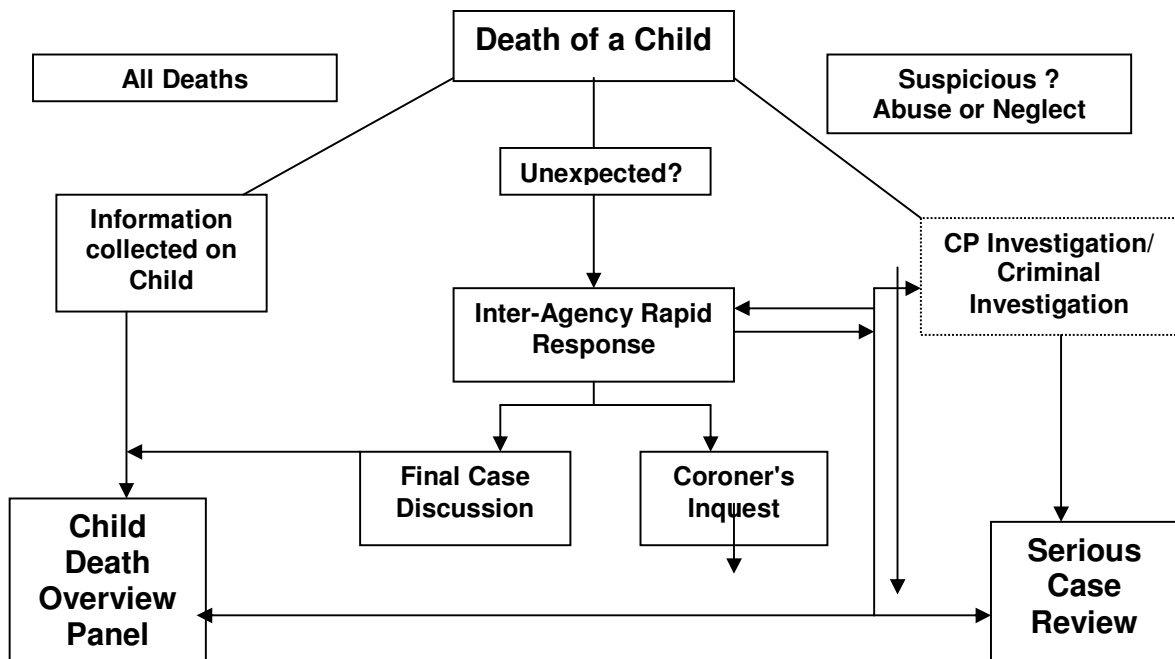
**And**

The case gives rise to concerns about inter-agency working to protect children from harm.

3.3 When a child has dies or has been seriously harmed and abuse or neglect is known or suspected the first priority must to ensure that any siblings or other children in the family are safeguarded.

### **4. Child Death Overview Panel (CDOP)**

4.1 All child deaths are reviewed through the child death overview process. The CDOP should consider at each stage of its review of a child death as to whether the criteria for a SCR is met. If a SCR is undertaken this will be completed prior to the final consideration CDOP. The following flow chart shows the process.



## 5. Decision Process

5.1 Any notification of a child death where abuse is suspected or known must be considered for a SCR and referred to the Standing SCR Panel (SSCRP). The Chairman of the Executive of the LSCB and the LSCB Manager will ensure that this is actioned following the child death notification.

5.2 Any professional can also make a referral for a SCR to be undertaken under the criteria set out above. Such a referral should be made through the agency's representative on the LSCB and should be made, in writing, with reasons, to the Chairman of the LSCB with copies to the Chairman of the SSCRP & the LSCB Manager.

5.3 The referral for a SCR should be considered by the SSCRP within 2 weeks of its receipt of the referral. The SSCRP (terms of reference for SSCRP appendix 1) will make a recommendation to the LSCB Chairman as to whether the criteria for an SCR are met. The decision to undertake a SCR lies with the LSCB Chairman and not the SSCRP Chairman. Within one month of the case coming to the attention of the LSCB Chairman a decision must be made. In practice this decision is likely to be made in a much shorter time frame.

5.4 The Chairman of the LSCB must notify Ofsted of the outcome of this decision as soon as it is made. Ofsted will share this information with the Department for Education. Bexley Care Trust should ensure the Strategic Health Authority and the Care Quality Commission are notified. The Police should notify HMIC.

5.5 In all cases and at all stages in the SCR process from the first notification to Ofsted to the completion of the SCR all information relating to the children, family members and

professionals involved in the case must be anonymised by the LSCB before being submitted to any external organisation or body.

5.6 Where more than one LSCB has knowledge of a child it is the LSCB for the area in which the child normally resides that must take the lead responsibility for the conducting the SCR but any other LSCB who has involvement should be included as partners in the process of the SCR.

5.7 If a child is Looked After it is the Responsible Authority that should instigate the SCR rather than the area in which the child has been placed &/or resided although involving any other LSCB with an interest or involvement.

5.8 The following questions may assist in deciding whether a SCR should be undertaken (taken from Working Together 8.12). If the answer is 'yes' to one or more of these questions it is likely indicate that there are potentially lessons to be learnt:

- Was there clear evidence of a risk of significant harm to the child that was:
  - not recognised by organisations or individuals in contact with the child or perpetrator **or**
  - not shared with others **or**
  - not acted on appropriately?
- Was the child killed or harmed by a parent, carer, parent's partner or close relative who was mentally ill, known to be misusing substances or perpetrating domestic abuse?
- Was the child abused in an institutional setting (eg school, nursery, family centre, Young Offender Institution, Secure Training Centre, children's home or Armed services training establishment)?
- Was the child abused or neglected while being looked after by a local authority?
- Did the child commit suicide?
- Was the child a member of a family that has recently moved to the UK eg as asylum seekers or temporary workers?
- Did the child die while absent from or having run away from home or care?
- Does one or more agency or professional consider that its concerns were not taken sufficiently seriously, or acted on appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding children procedures which go beyond the handling of this case?
- Was the child the subject of a child protection plan, or had been previously?
- Does the case appear to have implications for a range of agencies &/or professionals?
- Does the case suggest that the LSCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately disseminated, understood or acted upon?
- Are there indications that the circumstances may have national implications for systems, processes or in the public interest?

## **6. Instigating a Serious Case Review**

6.1 Following the decision of the LSCB Chairman to undertake a SCR the Chairman of the SSCR, the Deputy Director, Social Care & SEN and the LSCB Manager will be informed.

6.2 The LSCB Manager will ensure that a letter from the LSCB Chairman is sent to the chief executive of each relevant agency (copied to the LSCB representative) advising them of the decision to instigate a SCR and advising them that records relating to the child and their family need to be secured.

6.3 The LSCB Manager will convene the SCR Panel. At its first meeting it will confirm the membership of the SCR Panel to consider the Review (see appendix 2). The SCR Panel will be chaired by an Independent Chairman appointed for the duration of the SCR. The Chairman must not be a member of the LSCB, an employee of the agencies involved in the SCR or the overview writer. The Independent Chairman of the SCR Panel has the responsibility for managing the process and quality assuring the reports.

6.4 The LSCB Manager will identify an appropriate Independent Overview Writer for the SCR for the SCR Panel to consider & commission. The guidelines for appointing an Overview Writer are set down in appendix 3.

6.5 The SCR should be completed within 6 months of the decision date. Any request for an extension should be made in a timely fashion to (GOL?) with the reasons clearly identified and with a plan to demonstrate how the new timescale will be achieved.

### **7.1 SCR Process - Serious Case Review Panel**

7.1.1 Initial terms of reference will be agreed at the SCR Panel using the template in appendix 4. The Panel must agree the scope of the SCR. The Panel will refer to Working Together 8.20 when considering the scope of the review. The Panel must agree which agencies will be required to produce IMRs. The terms of reference will be shared with (GOL?) who will advise on any amendments or alterations. Once finalised the terms of reference must be sent to (GOL?) and the Strategic Health Authority.

7.1.2 The SCR Panel must consider how family members will be included in the SCR. It should be remembered that family members may be able to give significant information & insight into what has happened. The parents & family must be informed of the SCR at the beginning of the process. Consideration must be given as to the most sensitive and appropriate way for this to be done. They must be given information in writing so that they can share it with their family members and/or legal advisors. The Panel must consider how family members may contribute to the SCR and this should include grandparents & extended family. If the case is subject to criminal investigations all such considerations must be made in consultation with the Senior Investigating Officer & Coroner's Office. Appendix 5 has guidelines for family involvement.

7.1.3 The SCR Panel will reconvene once the IMRs and chronologies have been completed in line with the timeline set out in section 8 to consider the analysis and key issues identified applying challenge as necessary. At this point consideration should be given to the need for any expert opinion that may be required. The quality of IMRs will also be considered at this meeting. The Independent Overview Report Writer must

attend this Panel and all subsequent Panel meetings. A first draft of the Overview Report covering the narrative may be available at this meeting.

7.1.4 A third Panel should be held as set down in the timeline for the presentation of the Overview Report. This Panel will be convened with sufficient time to allow for a final Panel to be held prior to submission of the SCR if significant issues of dispute are identified or there is concern over the quality of the Overview Report. At this panel meeting consideration can be given to applying for an extension to the SCR timescale, if appropriate. This should only be done in exceptional circumstances; any extension has to be agreed by (GOL?).

7.1.5 The SCR Panel is responsible for achieving a consensus on the key issues and learning points to be included in the Overview Report, however the Overview Report Writer must be allowed to provide appropriate challenge where necessary without undue influence from Panel members. The Panel must approve the Overview Report and recommend its acceptance to the LSCB. The Chairman of the LSCB has delegated responsibility for the final 'sign off' of the completed SCR in consultation with the Director of Children's Services. All SCR paperwork and reports must be provided to the Chairman of the LSCB at least two weeks before the date for submission.

## **7.2 SCR Process - IMR Author's Group**

7.2.1 An IMR Author's Group will be convened by the LSCB Manager. This will be chaired by the LSCB Manager or delegated SCR Panel member. This Group should meet within 2-3 weeks of the decision to instigate the SCR in line with the timeline set out in section 8..

7.2.2 At the first meeting of the Author's Group all IMR authors will participate in a workshop training event to prepare them for the task of writing an IMR. This meeting will consider the terms of reference and scoping of the SCR. The 'why' questions can be explored at this meeting. Agreement will be reached at this meeting regarding what form of anonymisation will be used

7.2.3 All agencies involved must secure its records relating to the case to guard against loss or interference. As soon as the decision to convene an SCR is made agencies must draw up a chronology of their involvement with the child and family. This will inform who should be interviewed as part of the SCR.

7.2.4 The agency representative, will decide who should be interviewed in respect of the IMR and who should undertake these interviews. Records of all interviews should be made and agreed with the interviewee. The IMR author may be joined by another member of their agency staff with safeguarding expertise or, if an external view is considered appropriate, an agreed external person who is either independent or from another LSCB partner agency. When undertaking the interviews the emphasis should be on '**why**' rather than simply providing a narrative. The Author's Group can consider the common 'why' questions based on the agreed terms of reference.

7.2.5 All IMR Authors will be expected to complete their reports using the Framework in Appendix 6 and guidance in WT (8.34-8.39) They will also collate their agency's chronology using the template in this Framework.

7.2.6 An IMR is a stand alone document. It must include a summary of events and analysis and challenge under the headings outlined in the Framework. It should look openly and critically at individual and organisational practice, in the context of in which people were working, to see whether improvements/lessons are indicated. The terms of reference agreed by the SCR Panel must be fully & directly addressed. The IMR must be child focused and include clear analysis of the impact of the events on the child and their well being. The issue of diversity and culture must be clearly analysed. Examples of good practice should be highlighted. The IMR should make clear and SMART recommendations for that agency directly related to the analysis. The Action Plan for the agency resulting from the IMR should relate all actions to improving outcomes for children. There must also be an identified plan for monitoring the implementation of the recommendations and the impact that changes are having i.e. are they achieving the outcome desired? Lessons must not wait until the process is complete and should be acted upon in a timely way.

7.2.7 The Independent Overview Writer will attend subsequent Author's Group meetings which will be held at least twice more (see section 8 for timings). The first will be held once chronologies are complete and first drafts are underway. This meeting will allow for common issues and learning and any gaps or contradictions in information from each agencies to be identified. It will also allow the Overview Writer to consider and question information in IMRs at an early stage. The second Author's Group will meet once IMRs are complete to ensure that all information has been shared and to consider individual agencies' recommendations. Again the Overview Writer can question the authors to clarify points & to quality assure the IMRs. All finalised IMRs must be quality assured by a senior officer within the agency who will be responsible for ensuring that the recommendations of the IMR & Overview report are acted upon. NB The Overview Report will include comment from the Overview Writer on the quality of IMRs.

7.2.8 All agencies contributing an IMR should make arrangements for all staff contributing to the Review receive feedback and are debriefed before the Overview Report is finalised

7.2.9 The Designated Nurse/Designated Doctor will produce an integrated health chronology and health overview report to review and evaluate the practice of all health agencies and professionals involved on behalf of Bexley Care Trust as commissioners. This will form the IMR on behalf of Care Trust. It may generate additional recommendations to those made by individual health organisations.

7.2.10 The SCR Panel & its chairman have the responsibility for ensuring that IMRs are quality assured and if there are areas of improvement the author will need to make changes in line with the comments of the SCR Panel. The Overview Writer may also recommend changes.

### **7.3 SCR Process - Overview Report**

7.3.1 From June 2010 the full Overview Report of a SCR will be published although confidential information may be redacted. The timing of the publication of the Overview Report will be dependent on any criminal or coronial processes and their completion. The report will be published on the LSCB website [www.bexleylscb.org.uk](http://www.bexleylscb.org.uk)

7.3.2 The Independent Overview Report Writer is key to providing a thorough review. They need to undertake a thorough piece of work, taking nothing as read. They must check information across agencies and directly with IMR authors as necessary.

7.3.3 The report must provide analysis and where necessary challenge to both agencies involved and the SCR Panel. The report should consider the root causes of any failings; it should focus on '**why**' questions rather than 'what happened'.

7.3.4 The Overview Report must focus on how the situation appeared at the time and not apply hindsight excessively. Hindsight is a useful tool and should be applied proportionately and when this is done it should be clearly stated.

7.3.5 The format for the Overview Report can be found in WT 8.40.

7.3.6 Should any members of the SCR Panel disagree with the analysis in the Overview Report and if consensus can not be achieved this should be recorded in the final Overview Report.

7.3.7 It is the responsibility of the Independent Chair of the SCR Panel together with the LSCB Manager to quality assure the Overview Report taking into account the views of Panel members. If the quality of the report falls below the standard that is required the Overview Writer must be informed and asked to address any issues as soon as possible. If this does not rectify the problem the matter will be raised with the LSCB Chairman by the Independent Chairman of the SCR Panel and a decision made as to whether the Report is of sufficient standard for the LSCB to ratify. If it is not, the matter must be raised with (GOL?) and an extension sought to allow for the matter to be addressed and, if necessary, an alternative Overview Report Writer to be appointed.

#### **7.4 SCR Process - Executive Summary**

7.4.1 An Executive Summary for the SCR will also be produced and follow the format set out in WT 8.42.

#### **7.5 SCR Process - Action Plan**

7.5.1 The LSCB Manager will be responsible for pulling together an Inter-agency Action Plan at the end of the SCR Process. This will include actions already taken to address lessons learnt and the progress on implementation. The template for the Action Plan is in appendix 7.

7.5.2 The Action Plan is also published.

7.5.3 The SSCRIP will be responsible for monitoring the progress of the implementation of the Action Plan & ensuring that it is embedded in practice. The SSCRIP may recommend any audit of practice to the LSCB Quality & Effectiveness Group to assess improvements in inter-agency working as a result of the recommendations of a SCR.

## 8. Timeline for Serious Case Review

<b>Timescale</b>	<b>Actions</b>	<b>Lead</b>
<b>Decision Process</b>		
Week 1- 2	SSCR Panel considers referral for SCR & makes recommendation	Chairman of SSCR/P/LSCB Manager
Week 1	Initial notification of Serious Incident to Ofsted	Deputy Director - Social Care & SEN
By Week 4	LSCB Chairman makes decision to instigate SCR	LSCB Chairman
<b>SCR Process - to be complete in 6 months</b>		
Day 1	Ofsted informed of decision SHA informed of decision	Deputy Director - Safeguarding Designated Nurse
Week 1	Letter to Chief Executives of all agencies to be included in SCR	LSCB Manager
Week 1	Agency records secured	LSCB Agency Representative
Week 1	Family members to be informed in writing and decision made who will be the link person for the family with the SCR Panel	Chairman of SCR Panel/ LSCB Manager
Week 2	Overview Report Writer to be identified and commission agreed by SCR Panel	SCR Panel Chairman /LSCB Manager
Week 2	Initial SCR Panel convened	SSCR/P Chair/LSCB Manager
Week 2 -3	Authors' Group convened - briefing provided	LSCB Manager
Week 3 -8	Chronologies and IMRs drafted	IMR authors
Week 8	Authors' group meeting with Overview Writer - analysis starts	LSCB Manager
Week 9-10	Merged chronology prepared	LSCB Manager
Week 12	SCR Panel to consider draft IMRs and initial analysis	SCR Chairman/LSCB Manager
Week 12	Start to draft Overview Report	Overview Report Writer
Week 16	Final Authors' Group	LSCB Manager
Week 20	Finalised health chronologies & IMRs submitted to Bexley Care Trust for Health Overview to be prepared	Designated Nurse & Doctor
Week 22	SCR Panel to consider Overview Report	SCR Chairman
Week 22	Final amendments made to Overview Report. Consideration as to whether another Panel is required. Draft Executive Summary prepared.	Overview Writer SCR Panel Chair

Week 22	Action Plan prepared	LSCB Manager
Week 24	Paperwork to LSCB & LSCB Chairman for agreement & sign off	LSCB Manager/LSCB Chairman
Week 26	SCR submitted to Ofsted Health Overview submitted to SHA	

## 9. Ofsted Evaluation

9.1 On completion the SCR is submitted to Ofsted by the LSCB Manager for evaluation against the descriptors set out in Appendix 8. The following papers are submitted to Ofsted;

- Terms of Reference and Scope of the SCR
- Overview Report
- Integrated Chronology
- Each IMR with its attached chronology and single agency action plan
- Any expert reports
- Inter-agency Action Plan
- Executive Summary

9.2 The same paperwork and the health analysis will be submitted to the SHA by the Designated Nurse.

## **Appendix 1 - Terms of Reference for Standing Serious Case Review Panel**

Bexley Local Safeguarding Children Board has established a Standing Committee to act as the Serious Case Review Panel (SSCRP); the following are the Terms of Reference were ratified at the LSCB meeting on 23 February 2009.

1. The SSCRPs membership is drawn from the LSCB and partner agencies' strategic safeguarding leads. The standing membership of the Serious Case Review Panel is:
  - LB Bexley Children & Young People's Services
  - Bexley Care Trust
  - Bexley Community Provider Unit
  - South London Healthcare Trust
  - Oxleas Foundation NHS Trust
  - Bexley Voluntary Service Council
  - Bexley Schools
  - Metropolitan Police Service (Borough Police)
  - Bexley LSCB Manager - In attendance
2. The SSCRPs is deemed to be quorate if the Chair and at least 4 agencies are represented, including health and social care services.
3. The SSCRPs is chaired by a rotating process across its constituent agencies. If a SCR is convened an Independent Chairman will be appointed.
4. The SSCRPs will meet at least 4 times a year. It will vary its meetings dependent on the requirements of a particular SCR.
5. The SSCRPs responsibilities are to:
  - Consider all cases that may meet the criteria for an SCR as referred by individual agencies. An extra-ordinary meeting of the SCRPs will be convened following any critical incident involving either the death of or serious injury to a child that may be as a result of abuse to consider whether a SCR should be undertaken.
  - Recommend to the Chairman of the LSCB when a SCR should be undertaken.
  - Establish a SCR Panel to manage a specific SCR ensuring that the core membership as above are represented by the strategic lead who is independent of direct line management of the case and the IMR writer for their agency/service. Any other agency providing an Individual Management Report (IMR) will be considered for membership. If the SCR involves agencies from another LSCB that LSCB should be invited to join the SCRPs for the case. It should ensure that at least one member of the SCRPs does not come from an agency involved in the SCR. Consideration should be given to whether the Chair of the SSCRPs is appropriate to chair a specific SCR.
  - To ensure that each agency involved in a SCR is able to identify an appropriate IMR author who has the capacity and knowledge to complete the review and that their agency does not put them under undue pressure or risk to undertake work beyond their competency. The agencies must also ensure that IMR author's are appropriately supported through work release, administrative and supervisory support.
  - To ensure that all IMR authors are independent of direct involvement or line management of the case.
  - Monitor the Inter-agency Action plan resultant from any SCR and ensure that all actions are implemented and where appropriate assess impact on practice and improved outcomes for children, recommending any further action required to the LSCB.
  - To have in place a media strategy to monitor media interest and ensure it is dealt with appropriately to reduce the impact on the staff involved as well as the family
  - Consider any guidance from the Government and/or Ofsted in respect of SCR management and ensure that the appropriate steps are in place to meet such guidance across all agencies.
  - Consider any research and information from the biennial analysis of SCR and Ofsted evaluation report, Learning Lessons and make recommendations to the LSCB on any key issues or implications for practice locally.

6. The specific SCR Panel for a SCR will have the following responsibilities:
- To set down the scope of the SCR using Working Together 2010 and the up to date guidance from DfE & Ofsted
  - To agree the Terms of Reference for the SCR using Working Together and up to date guidance from DfE & Ofsted.
  - To ensure that all agencies are aware of their responsibilities to secure all records that form part of the SCR and that all records relating to the contact the agency may have had with the individuals subject to the SCR are identified and available to the IMR author.
  - To ensure that each agency has identified which staff need to be interviewed and that appropriate arrangements are in place for all such interviews.
  - To appoint an Independent Overview Writer with the appropriate level of experience and expertise to meet the needs of the SCR
  - To consider whether external expert advice is required on any aspect of the SCR
  - To ensure an Author's group is established for the IMR writers to meet with the Overview Writer. The purpose of this group will be to provide support to the IMR writers, to ensure that chronologies and facts are accurately & consistently recorded across all IMRs, to ensure that IMRs address the terms of reference for the SCR and that sufficient hindsight and robust challenge has been applied in the IMRs
  - To consider how families are included in the SCR and who will be the point of contact for families in respect of the SCR
  - To manage any parallel investigations being undertaken such as Serious Untoward Incident Investigations
  - To monitor progress of both Coronial, Police and CPS investigations and to negotiate with coroners, police and CPS to enable information to be used and shared so as not to delay the finalisation of the SCR and the learning being disseminated. If necessary a meeting should be arranged between the SCR Chair, the police, coronial service & CPS to clarify how the review can be progressed
  - To ensure that the SCR is completed within the required 4 months and that IMR authors indicate as early as possible if the work can not be completed in the timeframe. If it is not possible complete the SCR within timescales the LSCB must apply for extensions in timely and appropriate fashion. Extensions should only be applied for in exceptional circumstances with clear reasons provided.
  - To challenge information & analysis included in IMRs to ensure that key issues of learning are identified as well as areas of good practice. This may involve challenge to agencies who are members of the SCR to ensure that the analysis is sufficiently robust and challenging with hindsight applied.
  - To ensure that arrangements are in place for the senior manager who commissioned the IMR for the agency to sign it off
  - To consider and quality assure all the IMRs and the Overview Report & Executive Summary to ensure that it meets the requirements of Working Together and the Ofsted guidance & descriptors.
  - To ensure all reports are signed off the SCR and to recommend it to the LSCB Chair to be signed off.
  - To ensure that as single agency learning is identified that this is actioned and that it does not wait until the end of the SCR process before it is implemented
  - To ensure the media strategy is implemented appropriately
  - To ensure that the Inter-agency Action Plan addresses the key issues identified in the SCR, adding additional recommendations if necessary
  - To ensure that the Inter-agency Action Plan is thorough with clear objectives that identify the outcome for children as well as identifying lead officers and appropriate timescales.

## **Appendix 2 - Membership of SCR Panel**

1. The core membership of the SSCRCP will form the basis of the membership of the SCR Panel.
2. The Independent Chairman will be appointed to chair the SCR Panel. The final decision on the chairing arrangements sits with the LSCB. The chairman has the responsibility for managing the process and quality assuring the reports. They should ensure that staff are appropriately supported during the process and that appropriate contact has been made with the family.
3. Any member of the SSCRCP who has had direct involvement with or management responsibility for the case being reviewed must stand down from the Panel. An alternative agency representative may be nominated.
4. All agencies with significant involvement in the case being reviewed should be represented on the SCR Panel but that member must be independent of direct involvement or line management of the case.
5. At least 2 members of the Panel should come from an agency or organisation with no involvement in the case being reviewed. They may come from an organisation outside of the scope of the review, the voluntary sector or external member with particular expertise.
6. The Designated Nurse & Designated Doctor represent the commissioning PCT (Bexley Care Trust) and will provide medical expertise & challenge.
7. If another authority has had involvement in the case being reviewed a representative of the LSCB from that area should be invited to join the SCR Panel and consideration should be given to any representation from agencies involved from that authority.

## **Appendix 3 - Overview Report**

### **1. Criteria for Appointing Overview Report Writer**

1.1 The Overview Report Writer plays a crucial role in the SCR process. They support the Panel in collating the issues raised by IMRs and providing the analysis of that information. They must provide independent challenge and have the skills to facilitate the learning process by providing clear analysis to Panel members in a non-threatening way. The analysis should focus on root causes and constantly refer back to the 'why' questions.

1.2 They must be able to make clear and SMART recommendations for change and learning to the SCR Panel.

1.3 The Overview Report Writer must have:

1. Extensive safeguarding experience as a practitioner and manager
2. Experience relevant to specific aspect of the SCR as defined by the SCR terms of reference where necessary
3. Experience of undertaking SCRs
4. Undertaken any training/accreditation as recommended by the DfE/Ofsted for Overview Report Writers
5. Proven ability to write high quality reports with clear analysis
6. Access to mentoring or supervision
7. Ability to quality assure own work
8. References must be provided

1.4 Expectations on the work commitment, hours to be undertaken and quality of report should be clearly set out in the commissioning process.

## **Appendix 4 - Terms of Reference for Serious Case Review (template)**

Good terms of reference are crucial to the success of the Review. A draft is prepared at the beginning of the process but this may be adapted or revised as issues come to light. The IMRs & Overview Report must directly address the agreed terms of reference. Guidance is included in WT 8.20

### 1. Decision to hold SCR

- Add date when date notification to Ofsted was made
- Add date when the LSCB Chairman (name & independence status) agreed to hold SCR and start date of the SCR
- State independence status of SCR Panel
- State name of Independent Chairman & Overview Writer
- Provide detail of why SCR is necessary using WT 8.11
- Identify reasons for any delays in deciding to hold SCR
- How will reports and review be anonymised?

### 2. Key Issues

- What specific issues or questions does this case raise?
- How will information be obtained and analysed?
- Are there any unusual factors in this case, what are they?
- Are there similarities with previous SCRs, what are they?
- Are there any failings which appear obvious at this stage?
- Do there appear to be any gaps in multi –agency working?
- Are there any issues which relate to ethnicity, disability or faith which may have a bearing on this review? If not, say so.
- Does the family's immigration status have any bearing on the case?
- Is there any known research which may assist?
- How should the review process take account of relevant learning from research eg the Biennial Overview of SCRs and from other SCRs undertaken by the LSCB?

### 3. Expert Opinion

- Are there 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?
- Would it assist the Panel to bring in an outside expert at any stage, to shed light on crucial aspects of the case?

### 4. Time period over which events should be reviewed

- Over what period should events be reviewed? How far back should enquiries go & what is the cut off point?
- What is the relevance of selecting this time period?
- What family history/background will help better to understand the recent past & present? How will this be summarised and included in reports?

5. Organisations to be involved in this SCR (identify which are universal /targeted /specialist services)

- Which organisations & professionals will be asked to contribute to this review & submit reports or otherwise contribute?
- What action will the LSCB take if there is a failure to co-operate with this review?
- Who will make the link with the relevant interests outside of the main statutory organisations e.g. independent professionals or schools, voluntary organisations
- What arrangements will be made to feedback to staff involved in the case and to de-brief them

6. Involvement of Family Members

- Are there any known factors that may affect the involvement of any family members e.g. criminal investigations? Who should be consulted in relation to this?
- Which family members will be asked to contribute and why?
- Are there issues around timing which may affect this dialogue?
- Who will be responsible for supporting family members involved? Have they had access to bereavement support and information for bereaved families available through CDOP?
- What resources will be required to facilitate this process?
- How will surviving children and family members be informed of the outcome of the review?

7. Other parallel reviews

- Are there other parallel investigations of practice e.g. Serious Untoward Incident (health), multi-disciplinary suicide review, homicide review where a parent has been murdered etc?
- If so, how can a co-ordinated or jointly commissioned review process best address all the relevant questions in the most economical way?
- What are the arrangements for co-ordinating and liaising with those involved?
- What problems may emerge in terms of confidentiality and sharing of information & how will they be addressed?
- What are the implications of any different or challenging timescales?

8. Involvement of organisations in other LSCB areas

- Are there any organisations involved with this family or any cross boundary issues which may involve other LSCBs?
- Who will take responsibility for contacting that LSCB to negotiate, manage and co-ordinate their involvement in the SCR process?
- What should be the respective roles & responsibilities of the different LSCBs with an interest?

9. Coroner's Inquiries/Criminal Investigations

- Are timescales for Coroners/criminal or civil proceedings known and will revised timescales for the SCR be likely?
- Who will liaise with the Coroner's office &/or Police/CPS?
- Has the Coroner issued any advice & how will this be addressed in the SCR?

10. Media Coverage/Enquiries

- How should any public, family & media interest be managed before, during & after review?
- Is there a communications/media strategy?
- How & when will the Executive Summary be published?
- How should any FOI requests relating to the case be handled & by whom?

#### 11. Legal Advice

- Does the LSCB need to obtain independent legal advice regarding any aspect of the proposed review? If yes give reasons

#### 12. SCR Review Timescales

- The review process should start within one month of the notification & should, unless extensions are agreed with (GOL?), conclude and be forwarded to Ofsted & copied to GOL within 6 months from the start date.
- What are the possibilities that these dates may change & why?

#### 13. Commissioning of an Independent Overview Report Writer

- Who is being proposed and why? Indicate any specific skills or knowledge required
- Specify in what way they are considered independent
- Overview Report will follow guidelines in 8.40 WT
- Specify what is expected of the Report writer & within what timescales?
- Who will be the link person for the Report writer?
- Clarify the process should the LSCB fail to ratify the final report

#### 14. Liaison with Ofsted & (GOL?)

- State who will liaise with (GOL?) over progress and if any extensions to timescales prove necessary.

## **Appendix 5 - Family Involvement Guidelines**

1. The involvement of the family can provide an insight into what happened for the child who has either been harmed or has died. They are able to give a different perspective and should be considered to be 'experts' in their own right.
2. When thinking about involvement of the family consideration should be given to involving key adults and siblings. It does not have to be just the parents who are involved, grandparents, aunts & uncles and extended family may have important information to share about what happened and how they perceive services where able to respond to the needs of the child.
3. The parents of the child must be informed as soon as possible of the decision to undertake a SCR. This must be done in a sensitive and compassionate way but is often best done in writing so that they have something to show relatives or their legal advisors. They are also able to refer back to the letter and recheck information. Consideration should be given to informing any other key family members.
4. This is a time of deep distress for family members who may or may not have contributed to what happened to the child. They will need the opportunity to grieve. Bereavement support and information through CDOP should be made available to them as early as possible.
5. If the parent, partner or other family members are subject to criminal investigation / proceedings guidance must be sought from the Senior Investigating Officer before a dialogue is opened with these members of the family. It may be possible to agree a set of questions that can be posed to the person that explores the way services responded to their needs without compromising any criminal investigation or proceedings.
6. It should be remembered that family members may not respond immediately or may indicate that they do not wish to be involved however they must be kept informed of the progress of the review and offered further opportunities to be involved as the Review progresses.
7. If there is a surviving sibling of sufficient age and understanding they should also be given the opportunity to contribute. This can be done directly through their parent, carer or social worker or indirectly through including information shared through other routes such as Achieving Best Evidence Interviews.
8. Wherever possible a meeting should be arranged with family members either collectively or individually as they prefer. This should only be arranged with the agreement of the Police/CPS if there are any criminal investigations/proceedings. The meeting should include the Overview Writer and a member of the SCR panel or LSCB Manager. The family should be helped to understand the SCR process and what its aims are. They should be supported in giving their story and views in respect of the events that lead to the child being harmed.
9. If a direct meeting is not appropriate either because the family member does not want it or it is against the advice of the Police then consideration can be given to asking for a written response to agreed set questions. This could be done directly with the family member or through an intermediary such as a legal advisor or another family member.

## Appendix 6 - Framework for IMRs



### **FRAMEWORK FOR INDIVIDUAL MANAGEMENT REVIEW (IMR) REPORT**

This framework should form the basis for all IMRs prepared for the Bexley LSCB Serious Case Review Panel.

The framework is based on the IMR questions set out in Working Together chapter 8. For each SCR undertaken the framework will be provided to each IMR writer with guidance on how the Terms of Reference could be included under each heading.

Attached also is the Ofsted descriptors, this provides information on the expectation on how SCRs & IMRs should be conducted.

#### **Front Page**

#### **Strictly Confidential**

**SERIOUS CASE REVIEW - (name of child, anonymised)**

**INDIVIDUAL MANAGEMENT REVIEW OF**

**(name of agency)**

**Prepared for Bexley LSCB Serious Case Review Panel**

Child & Family Details (anonymised - to include dates of birth)

Date of death (or near miss incident)

Author:Name:

Post:

Address:

Date:

## **1. INTRODUCTION**

1.1 Reason for review

1.2 Terms of Reference

1.3 Relevant information on those interviewed, management arrangements demonstrating off line management status of IMR author.

## **2. FAMILY INFORMATION**

2.1 Family composition, genogram

2.2 Summary of family circumstances and background as known to the particular agency

## **3. CHRONOLOGY**

3.1 A comprehensive chronology of agency's and/or professional involvement or contact with the subject child, their siblings and parents over the period of time set out in the SCR's Terms of Reference using the template provided by Bexley LSCB. The chronology should be attached to the IMR.

3.2 If the agency holds relevant historical information on the family including parents and/or current partners this should be set out in the IMR.

3.3 A summary of this chronology should included in the main body of the IMR.

- *Relevant Terms of Reference:*

## **4. ANALYSIS OF INVOLVEMENT**

4.0 This section should include a consideration of the events that occurred, the decisions made, and the actions taken or not taken. Where judgments 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** it did or didn't happen. Consider specifically the following:

**4.1 Were the practitioners sensitive to the needs of the child in their work, knowledgeable about potential indicators of abuse or neglect and about what to do if they had a concern about a child?**

- *Relevant Terms of Reference:*

**4.2 When, and in what way, were the child's wishes and feelings ascertained and taken account of when making provisions about children's services. Was this information recorded?**

*Even in very young children & babies it is important to record here how the child had presented to the workers and how well this was recorded and used to form decisions.*

**4.3 Did the organisation have in place policies & procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?**

- *Relevant Terms of Reference:*

**4.4 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?**

- *Relevant Terms of Reference:*

**4.5 Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?**

- *Relevant Terms of Reference:*

**4.6 Were there any issues, in communication or service delivery, between those with responsibilities for work during normal office hours and those providing out of hours services?**

- *Relevant Terms of Reference:*

**4.7 Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?**

- *Relevant Terms of Reference:*

**4.8 Was practice sensitive to the racial, cultural, linguistic and religious identity of the child & family? Were they explored and recorded?**

*Comment should be made about whether these issues were recorded & acted upon appropriately on agency files. Was there an assumption because a family were white/british that there were no such issues?*

- *Relevant Terms of Reference:*

**4.9 Were more senior managers or other organisations and professionals involved at point s when they should have been?**

*Relevant Terms of Reference:*

**4.10 Was the work in this case consistent with each organisation's and the LSCB policy & procedures for safeguarding and promoting the welfare of the children, and with wider professional standards?**

- *Relevant Terms of Reference:*

**4.11 Were there organizational difficulties being experienced within or between agencies? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?**

- *Relevant Terms of Reference:*

**4.12 Was there sufficient management accountability for decision making?**

- *Relevant Terms of Reference:*

## **5. WHAT DO WE LEARN FROM THIS CASE?**

**5.1 Are there lessons from this case for which this organization works to safeguard and promote the welfare of children? 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 & inter-agency); management and supervision; working in partnership with other organizations; resources? Are there implications for current policy & practice?**

- *Relevant Terms of Reference:*

## **6. RECOMMENDATIONS FOR ACTION**

**6.1 What action should be taken by whom and when? What outcomes should these actions bring and in what timescale and how will the organisation evaluate whether they have been achieved? Are there any immediate statutory requirements for the notifications of concerns and are there likely to be any media handling issues?**

*Individual action plans should be attached to the final IMR. learning should not wait until the end of the process and the SCR Panel will monitor each agency action plan as well as the LSCB action plan. All such action plans should be outcome based and evidence provided on implementation and achievement.*

### **SIGNED & DATED**

Author of IMR  
Date

Head of Agency  
Date

**INDIVIDUAL MANAGEMENT REVIEW CHRONOLOGY**

**SUBJECT'S NAME**

Date & Time (if known)	Family Contact		Communication		Response And/or outcome	Source of evidence	Comment
	Child <i>Specify if her/his views recorded &amp; if seen alone</i>	Adult <i>Specify if her/his views recorded</i>	Within Agency <i>Specify: phone, written, meeting</i>	External to Agency <i>Specify: phone, written, meeting</i>			

### Single Agency Action Plan

<b>RECOMMENDATION</b>	<b>OUTCOME</b> What do we intend to achieve for children & their families?	<b>ACTION</b> What are we going to do?	<b>BY WHOM</b> Who is going to do it?	<b>BY WHEN</b> Timescales including breaking it down into stages if necessary	<b>MONITORING</b> How will this be assessed? What has been achieved? What else do we need to do? <b>RAG rating</b>

Appendix 7 - Framework for Inter-agency Action Plan



**BEXLEY LOCAL SAFEGUARDING CHILDREN BOARD**  
**SERIOUS CASE REVIEW**  
**ACTION PLAN**  
**CHILD**

Date

NB This Action Plan sets out the Recommendations made to both the LSCB & to individual Agencies through the Overview Report & IMRs

Prepared by:

LSCB Manager  
London Borough of Bexley

<b>RECOMMENDATION</b>	<b>OUTCOME</b> What do we intend to achieve for children & their families?	<b>ACTION</b> What are we going to do?	<b>BY WHOM</b> Who is going to do it?	<b>BY WHEN</b> Timescales including breaking it down into stages if necessary	<b>MONITORING</b> How will this be assessed? What has been achieved? What else do we need to do? RAG rating
<b>1. General Actions</b>					
1.1 Dissemination of the key findings including good practice, Overview Report & Executive Summary. Debriefing of Staff					
1.2 Link with Child Death Overview Panel (CDOP)					
1.3 Feedback to family members					
1.4 Media Management					
1.5 Implementation & progress of Action Plan					
<b>2. LSCB Recommendations</b>					
<b>3. Single agency Recommendations</b>					

## Appendix 8 - Descriptors for the Evaluation of Serious Case Reviews

	<b>Outstanding</b>	<b>Good</b>	<b>Satisfactory</b>	<b>Inadequate</b>
<b>Timescales</b>	Requests for extension to the timescale timely and are agreed by Government Office; delays are unavoidable and the review is completed within the agreed timescale.	Requests for extension to the timescale are timely and are agreed by Government Office. Any delays in completion of the review are unavoidable and it is completed broadly in line with an agreed time scale.	All extensions to the timescales are agreed by Government Office. There are delays in the completion of individual management reviews and the overview report, some of which are avoidable.	The timescale for the review is outside the four month guidance and has not been agreed by Government Office. The delay in completion of the review impedes the timely dissemination of the lessons to be learned.
<b>Scope of the review</b>	The decision to conduct a serious case review is appropriate. The scope of the review unambiguous, outcome focussed and covers an appropriate time period to be investigated. It is supported by clear terms of reference which ensure that all relevant questions can be addressed through all the available information and the analysis completed within the agreed time scale. Good contingency arrangements, help to ensure timely responses to new information or changes during the process of the review.	The decision to conduct a serious case review is appropriate. The scope of the review unambiguous, outcome focussed and covers an appropriate time period to be investigated. It is supported by clear terms of reference which ensure that nearly all relevant information can be obtained and analysed within the agreed time scale.	The decision to conduct a serious case review is appropriate. The scope of the review is defined and is supported by terms of reference which support the collation and analysis of most of the relevant information available to agencies.	The decision to conduct a serious case review is inappropriate; the criteria set out in WT are not met. The scope of the review is unclear or too limited. It is supported by imprecise terms of reference which fail to ensure that the relevant information can be obtained and analysed.
<b>Contribution of relevant agencies</b>	The contribution of all relevant agencies is maximised throughout the period of the review.	The contribution of all relevant agencies is secured.	The contribution of nearly all relevant agencies is secured.	The contributions of some relevant agencies are not secured.
<b>Independent element</b>	A high level of independence is built into the process including the appointment of an	Independence is built into the process through the appointment of an independent author of the	Independence is built into the process through the appointment of an independent author of the	Insufficient independence is built into the process such as the appointment of an independent

	independent author of the overview report and access to expert advice on critical or complex aspects of the case. The independent author is not a member of the serious case review panel. . The serious case review panel include members who hold expert knowledge of the issues relevant to the case. Authors of individual management reviews are independent of line management of the service.	overview report. The independent author is not a member of the serious case review panel. The serious case review panel has access to legal advice on critical aspects of the case. Authors of individual management reviews are independent of line management of the service.	overview report The independent author is not a member of the serious case review panel. Most individual management review authors are independent of line management of the service. Where this level of independence is not possible, the serious case review panel has demonstrated sufficient transparency and critical analysis of both the individual management reviews and overview report.	author of the overview report. The serious case review panel does not include an independent member. Authors of individual management reviews are not independent of line management of the service.
<b>Involvement of family members</b>	Arrangements to involve and support relevant family members are comprehensive, appropriate, effective and take into account their ethnic, cultural, linguistic and religious needs.	Clear and appropriate arrangements have been put in place to secure the involvement of relevant family members. Where their involvement was not possible, the reasons are recorded and the members informed of the outcome of the review.	Arrangements have been put in place for relevant family members to contribute information to the review.	The contributions of relevant agencies are not clearly defined and arrangements for the involvement of relevant family members have not been agreed.
<b>Links to parallel investigations</b>	All other parallel investigations including criminal investigations and coroner's enquiries are considered and where appropriate, effective information sharing processes or jointly commissioned review arrangements have been agreed.	Other parallel investigations including criminal investigations and coroner's enquiries are considered and where appropriate effective information sharing processes are in place.	Some parallel investigations such as criminal investigations and coroner's enquiries are identified and the outcomes of these are considered within the review.	Some parallel investigations including criminal investigations and coroner's enquiries have not been considered within the scope of the review and processes for communication are unclear.
<b>Individual management reviews</b>	All relevant agencies produce a comprehensive and well-structured management review of their full involvement with the child(ren) and family.	Most relevant agencies produce a comprehensive management review of their full involvement with the child and family.	Most relevant agencies produce individual management reviews of their involvement with the child and family.	Not all relevant agencies produce a management review of their involvement with the child 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.	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.	Most reviews take into account the individual needs of the child and family and record their racial, cultural, linguistic and religious identity.	Some reviews do not take into account the individual needs of the child and family including their racial, cultural, linguistic and religious identity.
	Practice at individual and organisational levels is analysed openly, thoroughly and critically against national and local statutory requirements, professional standards and current procedural guidance. The information provided is comprehensive and fully addresses the terms of reference.	Practice at individual and organisational levels is analysed openly and critically against national and local statutory requirements, professional standards and current procedural guidance. The information provided fully addresses the terms of reference.	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 explained.	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.
	Good practice is highlighted with appropriate consideration of its potential for wider implementation. Areas for changes in practice are clearly identified and supported with measurable and specific recommendations for improvement.	Good practice is highlighted. Nearly all areas for changes in practice are clearly identified and supported with measurable and relevant recommendations for improvement.	Areas for changes in practice are mostly identified and supported with measurable and relevant recommendations for improving practice.	Some areas for changes in practice are identified but are not always supported with measurable and relevant recommendations for improvement.
<b>Overview report</b>	The overview report coherently and accurately 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	The overview report accurately ly 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	The overview report brings together the key 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	The overview report does not bring together effectively 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

	comprehensive and well-organised chronology which maintain a clear focus on the child(ren) concerned throughout.	events relating to the history of the child and family and agency involvement	of the child and agency involvement.	family history, circumstances of the child and agency involvement which impact adversely on the coherence of the report.
	Outcomes for the child(ren) are transparent and well evidenced by the information known to the agencies and professionals concerned about the parents, child and perpetrators, the family history and home circumstances.	Outcomes 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	Reference is made to the most important aspects of the information was known to the agencies and professionals concerned about the parents, carers and perpetrators, the family history and home circumstances of the child.	Reference is not always made to or effective use made of 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 reflects a robust examination of the facts and provides evidence-based explanations for how and why events occurred and actions or decisions by agencies were or were not taken.	The report reflects a critical examination of most facts and provides evidence-based explanations for how and why most events occurred and actions or decisions by agencies were or were not taken.	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 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 benefits of hindsight and evidence from research and previous reviews are used comprehensively by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events.	The benefits of hindsight and research findings are used appropriately by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events.	The benefits of hindsight are used appropriately by reviewers to judge whether different actions or decisions by agencies may have led to an alternative course of events.	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 supported by the evidence..
<b>Lessons to be learned</b>	Lessons to be learned, nationally and locally, are clearly identified and supported by specific and achievable recommendations for improving practice in a timely manner.	Lessons to be learned, nationally and locally, are nearly all identified and supported by specific and achievable recommendations for improving practice.	Lessons to be learned, nationally and locally, are identified and supported by relevant recommendations for improvement.	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.
<b>Action plan</b>	A comprehensive joint agency action plan is in place, which	A joint agency action plan is in place, which matches the	A joint agency action plan is in place, which matches the	The joint agency action plan is not robust, and is not SMART.

	<p>matches the recommendations of the overview report, and contains clear lead responsibilities for action and target timescales for completion. The plan is outcome focussed and includes actions to disseminate good practice as well address areas for improvement. Robust arrangements are in place for the local safeguarding children board to monitor progress and evaluate the impact of actions taken.</p>	<p>recommendations of the overview report, and contains clear lead responsibilities for action and target timescales for completion. Arrangements for the local safeguarding board to monitor the plan and evaluate outcomes are identified.</p>	<p>recommendations of the overview report. Most aspects are supported by targets and lead responsibilities. Arrangements for the local safeguarding board to monitor the plan and evaluate outcomes are identified.</p>	<p>Arrangements for monitoring by the local safeguarding children board are not identified/not robust.</p>
<b>Executive summary</b>	<p>An executive summary is completed and includes succinct information about the review process, practice issues and lessons learned from the case and recommendations which have been made. The summary is suitably anonymised to protect the confidentiality of the child/family members. Firm arrangements are in place for the publication of the executive summary, including progress on actions required as a result of the review. The executive summary is shared with the family as appropriate.</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. The summary is suitably anonymised to protect the confidentiality of the child/family members. Firm arrangements are in place for the publication of the executive summary, and for sharing the executive summary with the family.</p>	<p>An executive summary is completed and includes most relevant information about the review process, key issues arising from the case and recommendations which have been made. The summary is suitably anonymised to protect the confidentiality of the child/family members. Firm arrangements are in place for the publication of the executive summary and for sharing the executive summary with the family.</p>	<p>An executive summary is completed but there are gaps or contradictions in information about the review processor key issues arising from the case and recommendations which have been made. The summary is not suitably anonymised to protect the confidentiality of the child/family members. Arrangements for the publication of the review are not robust. No arrangements have been made to share the executive summary with the family.</p>