



Bath & North East Somerset  
Local Safeguarding Children Board

## **Notifiable Incidents, Serious Case Review and Other Multi-Agency Review Procedures**

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## 1. Introduction

1.1 In January 2015 the Department for Education undertook a consultation process regarding proposed changes to Working Together 2013. The purpose of this revised version of the Serious Case Review Process is to take into account the revisions made following the consultation as set out in Working Together to Safeguard Children 2015 (WT2015) (published 26<sup>th</sup> March 2015). The Process also includes what to do with notifiable incidents. The Process also includes changes made to the LSCB Multi-Agency Serious Case Review (SCR) sub group. Note this process does not replace the role of the Child Death Overview Panel as outlined in chapter 5 of WT2015.

## 2. Criteria for Notifiable Incident and SCR

2.1 A **Notifiable Incident** as set out in WT2015 is as follows:

*‘An incident involving the care of a child which meets any of the following criteria:*

- *A child has died (including cases of suspected suicide), and abuse or neglect is known or suspected;*
- *A child has been seriously harmed and abuse or neglect is known or suspected;*
- *A looked after child has died (including cases where abuse or neglect is **not** known or suspected); or*
- *A child in a regulated setting or service has died (including cases where abuse or neglect is **not** known or suspected).’ (p74 WT2015)*

2.2 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCB’s. This includes the requirement for LSCB’s to undertake reviews of serious cases and advise on lessons to be learned in specified circumstances, namely:

*‘5 (2) For the purpose of paragraph (1) a serious case is one where:*

- (a) abuse or neglect of a child is known or suspected: **and***
- (b) either – (i) the child has died; or  
(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority their Board partners or other relevant persons have worked together’ (p75 WT2015)*

2.3 WT2015 guidance clarifies the term “seriously harmed” for which the definition now reads as:

- *A potentially life threatening injury;*
- *Serious and/or likely long term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.*

*This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. The LSCB should ensure that their considerations on whether serious harm has occurred are informed by research evidence.*

*Cases which meet one of the criteria (i.e. regulation 5(2)(a) and (b)(i) or 5(2)(a) and (b)(ii) **must always** trigger an SCR. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide. Where a case is being considered under regulation 5(2)(b)(ii) unless there is definitive evidence that there are no concerns about inter agency working the LSCB **must** commission an SCR.*

*In addition, even if one of the criteria is not met, an SCR **should always** be carried out when a child dies in custody, police custody, on remand or following sentencing, in a Young Offenders Institution, or in a secure children's home. The same applies where a child dies who was detained under the Mental Health Act 1983 or where a child aged 16 or 17 years was the subject of a deprivation or liberty order under the Mental Capacity Act 2005. (p76 WT2015)*

### **3. What to do if the Criteria for Notifiable Incident is Met**

- 3.1 The local authority should report any incident that meets the above criteria (see 2.1) to **Ofsted** and the **LSCB** within **five working days** of becoming aware that the incident has occurred.
- 3.2 Note the guidance is clear that if an incident meets the criteria for a Serious Case Review (see 2.2) *then it will also meet the criteria for a notifiable incident. There will, however, be notifiable incidents that do not proceed through to Serious Case Review.* (p75 WT2015)

### **4. How to Initiate a SCR and the Decision Making Process**

- 4.1 The LSCB for the area in which the child is normally resident must decide whether an incident notified to them by lead agencies meets the criteria for a SCR.
- 4.2 Where an agency believes the SCR criteria has been met they must complete Appendix 1 and send this to the Chair of the LSCB; this must be done securely either through the post or via the secure email address for the attention of the LSCB Chair and the LSCB SCR sub group Chair.

[Safeguarding.AdministrationTeam@bathnes.qcsx.gov.uk](mailto:Safeguarding.AdministrationTeam@bathnes.qcsx.gov.uk)

- 4.3 Upon receipt of the notification the Chair of the LSCB SCR sub group will write to all agencies named in the notification to gather information about their involvement with the child to help inform the sub group discussion. This will be required through the completion of Appendix 2.

- 4.4 The LSCB SCR sub group will discuss the collated information at either the next scheduled meeting or an extraordinary sub group convened specifically to discuss the notification.
- 4.5 The LSCB SCR sub group will consider the information and make a recommendation as to whether the SCR criteria has been met to the LSCB Chair. The group will also make a recommendation for a different type of review to be carried out if the criteria is not met.
- 4.6 The **LSCB Chair** will make the **final decision** which should normally be made within **one month** of the notification (p78 WT2015)
- 4.7 The LSCB Chair may seek *peer challenge from another LSCB Chair when considering this decision (and also at other stages in the SCR process)*. (p78 WT2015)
- 4.8 The flow chart in Appendix 3 sets out the procedure described above.

## **5. Notification of the Decision**

- 5.1 If the Chairs decision is to progress with a SCR they will notify Ofsted, DfE and the National Panel of Independent Experts aware within five working days.
- 5.2 If the Chair's decision is not to initiate a SCR the decision will be subject to scrutiny by the National Panel. The Chair will inform the National Panel of the decision not to progress and will send the Panel the completed notification (Appendix 1) which includes the SCR sub groups recommendation and Chairs decision.
- 5.3 Where the National Panel require further supporting information regarding the decision making this will be provided and could include the information provided by agencies in Appendix 2 as well as the minutes of the SCR sub group meeting.
- 5.4 As set out in WT2015 if the *LSCB is challenged by the National Panel to change its original decision, the LSCB should inform Ofsted, DfE and the National Panel of the final outcome.*' (p78 WT2015)

## **6. Engagement of Families**

- 6.1 Engagement of families, children and service users. There is an increasing body of evidence that family members, including surviving children, can make a valuable contribution to professional understanding and should be invited to contribute to the review process. Consideration will be given to the earliest point that the family will be involved.

## **7. Procedure for Carrying Out a SCR**

- 7.1 Appendix 4 sets out what actions are required once agreement has been reached to commission a Serious Case Review.

## **8. Publication of Reports**

- 8.1 In order to provide transparency and to support the sharing of lessons learnt and good practice in writing and publishing such reports, all reviews of cases meeting the Serious Case Review criteria will result in a readily accessible published report on the LSCB's website. It will remain on the web-site for a minimum of 12 months and thereafter be available on request.
- 8.2 The fact that the report will be published must be taken into consideration throughout the process, with reports written in such a way that publication 'will not be likely to harm the welfare of any **children** or **Vulnerable Adults** involved in the case' and consideration given on how best to manage the impact of publication on those affected by the case. The LSCB will comply with the Data Protection Act 1998 and any other restrictions on publication of information, such as court orders.
- 8.3 The final Serious Case Review report should:
- Provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
  - Be written in plain English and in a way that can be easily understood by professionals and the public alike; and
  - Be suitable for publication without needing to be amended or redacted.
- 8.4 The LSCB will publish, either as part of the final Serious Case Review report or in a separate document, information about:
- Actions already taken in response to the review findings;
  - The impact these actions have had on improving services; and
  - What more will be done
- 8.5 The LSCB will send copies of all Serious Case Review reports to the National Panel of Independent Experts at least one week before publication. If the LSCB considers that a report should not be published, it should inform the panel which will provide advice. The LSCB will provide all relevant information to the panel on request, to inform its deliberations.

## **9. Carrying out Learning and Improvements Through Undertaking a Multi-Agency Case Review**

- 9.1 The LSCB SCR sub group can also consider requests for convening multi-agency case reviews which do not meet the threshold for a serious case review and would benefit from a fuller review than what can be provided by

the multi-agency audit sub groups. Chapter 4 of WT15 sets out the requirement to undertake these linked to the LSCB Learning and Development Framework.

- 9.2 The purpose of these reviews is to provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children. Although this is not a statutory requirement these reviews are important for highlighting good practice as well as identifying improvements which need to be made to local services. This is set out in Regulation 5(2). The LSCB Chair should be confident that their review will thoroughly, independently and openly investigate the issues. The LSCB will also want to review any instances of good practice and to consider how these can be shared and embedded into practice. The LSCB sub group should oversee implementations of actions resulting from these reviews and reflect on any progress in its annual report.

## **10. Procedure for Carrying Out a Multi-Agency Review**

- 10.1 Where an agency believes the SCR criteria is not met but that a multi-agency review would be of benefit they should complete Appendix 6.
- 10.2 The LSCB SCR sub group will consider the information provided on Appendix 6 and follow the flowchart in Appendix 5, decide the type of review to take place and recommend this to the LSCB Chair for approval.
- 10.3 The SCR sub group will be responsible for monitoring any related action plan which is agreed as part of the review.
- 10.4 WT2015 does not prescribe any particular methodology to use in continuous learning and improvement except that whatever model is used should be conducted in a way that adheres to the following 5 principles:
- Recognises the complex circumstances in which professionals work together to safeguard children;
  - Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
  - Seeks to understand practice from the viewpoint of the individuals and organisations; involved at the time rather than using hindsight;
  - Transparency about the way data is collected and analysed; and
  - Makes use of relevant research and case evidence to inform the findings.
- 10.5 WT2015 stops short of advocating any specific method. However, the systems methodology as recommended by Professor Munro (**The Munro Review of Child Protection: Final Report: A Child Centred System**) is cited as an example of a model that is consistent with these principles.  
<https://www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system>

10.6 The following principles should be applied by the LSCB and partners organisations to all reviews

- **The child to be at the centre of the process**
- **A proportionate response:** according to the scale and complexity of the issues being examined i.e. the scale of the review is not determined by whether or not the circumstances meet statutory criteria
- **Independence:** reviews of serious cases to be led by individuals who are independent of the case and of the organisations being reviewed
- **Involvement:** of practitioners and clinicians: Professionals should be fully involved in reviews and invited to contribute their perspective without fear of blame for actions they took in good faith
- **Family involvement:** Families, including surviving children, should be invited to contribute and be provided with an understanding of how this will occur
- **Transparency:** by publishing the final report of the Serious Case Review and the LSCBs findings. The LSCB annual reports should explain the impact of the serious case review and other reviews on improving services to children and families and on reducing incidence of deaths or serious harm
- **Embedding learning:** using a range of creative communication and methodologies
- **Sustainability:** improvement must be sustained through regular monitoring and following up the finding from these reviews that make a real impact on improving outcomes for children

## 11. Parallel processes

### 11.1 NHS Serious Incident Investigations

Serious Incidents in the NHS include abuse that resulted in (or was identified through) a Serious Case Review (SCR). The revised National Health Service England (NHSE) serious incident framework, implemented from April 2015, explains the responsibilities and actions for dealing with Serious Incidents. It outlines the process and procedures to ensure that Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. Healthcare providers must contribute towards SCR's as required to do so by the Local Safeguarding Board.

(See **Serious Incident Framework: Supporting learning to prevent recurrence, NHS England (Updated: March 2015)**).

When the NHS is involved in a SCR, an NHS Serious Incident Investigation is carried out in parallel coordinated by a Designated Safeguarding Professional employed by the Clinical Commissioning Group (CCG). The Serious Incident investigation must include all provider organisations that were involved in the child's care during the period of time under review. Lessons will be defined and recommendations and actions made with regards to NHS interdepartmental, interdisciplinary and inter-

agency working as well as those for multi-agency practice. The NHS Serious Incident Investigation must use Serious Incident RCA systems methodology, which is compliant with the principles in Working Together to Safeguard Children 2015. The CCG Designated Safeguarding Professional coordinating the case must have an early discussion and agree with the Chair of the Safeguarding Board the ways in which the SI investigation can best inform the SCR whilst avoiding duplication, for example by enabling health to undertake joint interviews with the LSCB lead reviewer for the health professionals involved, and attending all SCR multi-agency review meetings and learning events.

## **11.2 Domestic Homicide Reviews**

When there has been a death of an individual of 16 years or over which has, or appears to have, resulted from violence, abuse or neglect by a person to whom s/he was related to, had been in an intimate personal relationship or was a member of the same household then a Domestic Homicide Review (DHR) or Serious Incident review will be undertaken. If the deceased person was 16 – 18 years then a Serious Case Review will be undertaken, with the Domestic Violence fully considered and shared with the Community Safety Partnership. The LSCB is involved in all reviews where there are children living in the house and the findings and recommendations are shared with the LSCB.

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/97881/DHR-guidance.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97881/DHR-guidance.pdf)

## **11.3 Criminal investigation/prosecution**

Where a Serious Case Review is to take place where there are to be criminal proceedings, the LSCB and Police will operate within the Crown Prosecution Service suggested framework for the sharing and exchange of relevant information which can be found on the CPS website:

[http://www.cps.gov.uk/publications/docs/liaison\\_and\\_information\\_exchange.pdf](http://www.cps.gov.uk/publications/docs/liaison_and_information_exchange.pdf).

The framework deals with the process of a serious case review and how it may affect the conduct of the criminal investigation/prosecution. Both criminal proceedings and serious case reviews are crucial to the effective safeguarding of children and should be carried out as expeditiously as possible and without one adversely affecting the other. The CPS suggested framework should be read in conjunction with wider CPS Legal Guidance on the CPS website:

[http://www.cps.gov.uk/legal/s\\_to\\_u/serious\\_case\\_review/index.html](http://www.cps.gov.uk/legal/s_to_u/serious_case_review/index.html).

## **12. Further Information**

- <https://www.gov.uk/government/publications/childrens-safeguarding-performance-information-framework>
- <https://www.gov.uk/search?q=Working+Together+to+Safeguard+Children>

- <https://www.gov.uk/government/publications/munro-review-of-child-protection-interim-report-the-childs-journey>
- <https://www.gov.uk/government/publications/good-practice-by-local-safeguarding-children-boards>
- <https://www.gov.uk/government/consultations/inspection-of-services-for-children-in-need-of-help-and-protection-children-looked-after-and-care-leavers>
- <https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2>
- <https://www.gov.uk/government/publications/keeping-children-safe-in-education--2>







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## Appendix 2 Request for Agency Case Information Form

**Name of Agency:**

**Name of Person Completing the Form:**

**Date Information Required by:**

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others.

LSCBs should also conduct reviews of cases which do not meet the criteria for an SCR, but which can provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children. Although not required by statute these reviews are important for highlighting good practice as well as identifying improvements which need to be made to local services. Such reviews may be conducted either by a single organisation or by a number of organisations working together.

Your agency has been cited as being involved in delivering care to a child and parents and the case has been referred to the B&NES LSCB to consider if it meets the requirement for a serious case review or other form of review as appropriate. Please use this form to provide information on your agencies involvement with the child and adults.

This can be a brief outline and the LSCB may request more information at a later stage if required – it will help the SCR sub group to determine next steps.

**TIMEFRAME:**

**PERSON PROVIDING THIS INFORMATION**

<b>Date</b>		<b>Landline telephone</b>	(01225) 396339
<b>Name</b>	Lesley Hutchinson	<b>Email</b>	Lesley_Hutchinson@bathnes.gov.uk
<b>Role</b>	Head of Safeguarding and Quality Assurance	<b>Agency</b>	B&NES Council

**CHILD DETAILS**

<b>Surname</b>		<b>Address</b>	
<b>First name</b>			
<b>Date of Birth</b>		<b>Gender</b>	
<b>Ethnicity</b>		<b>Language</b>	
<b>School</b>		<b>GP</b>	

**CHILD'S PARENTS**

	<b>Mother</b>	<b>Father</b>
<b>Name</b>		
<b>Date of Birth</b>		
<b>Address</b>		
<b>Telephone</b>		
<b>Ethnicity</b>		

**Completion of Chronology Table – significant dates and events**

Date	Event

**Brief Overview of Case Record Relating to Child and Parents  
(include detail of the record that was reviewed)**

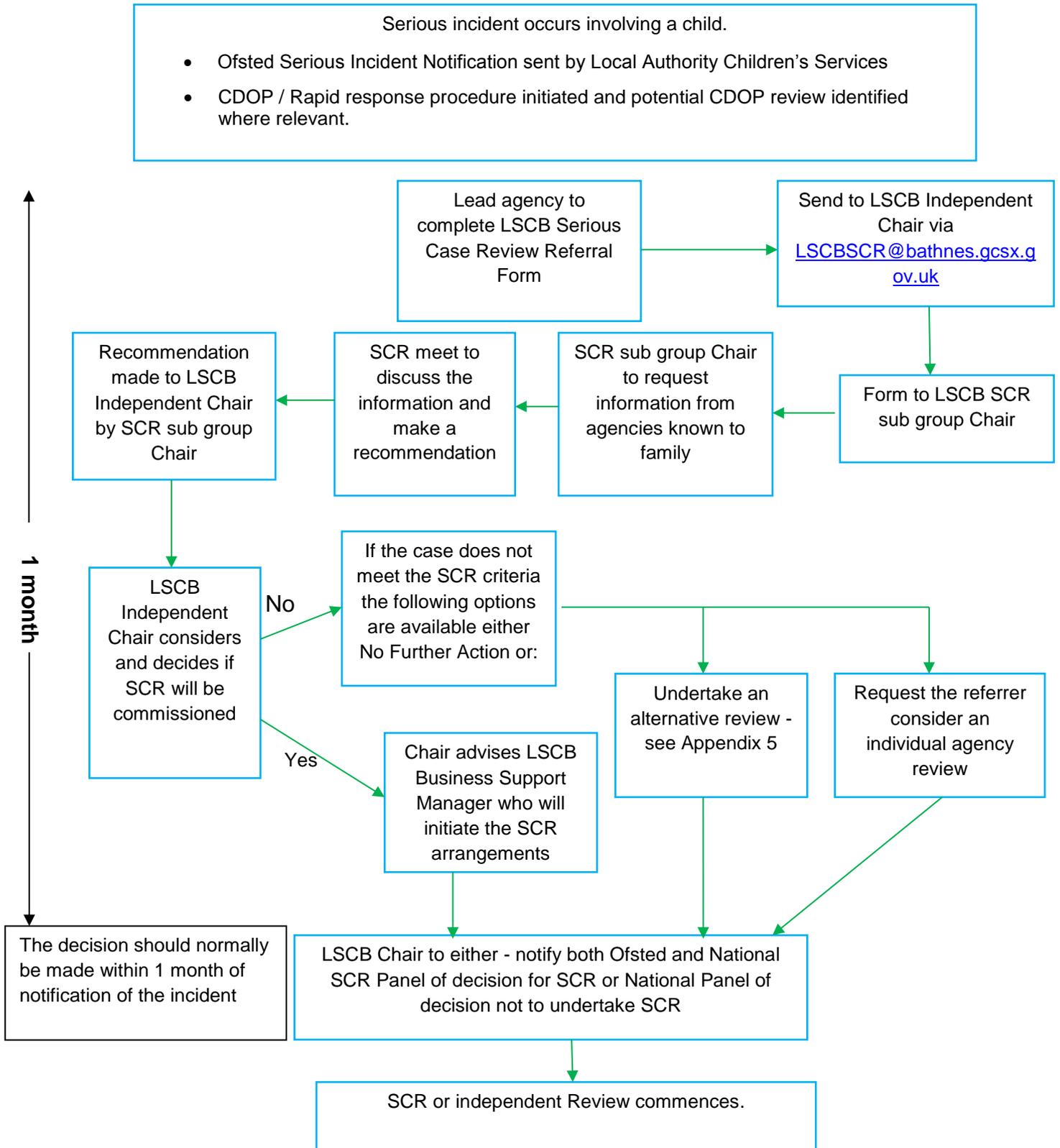
**Please send this form via secure email transfer to:**

[LSCBSCR@bathnes.gcsx.gov.uk](mailto:LSCBSCR@bathnes.gcsx.gov.uk)

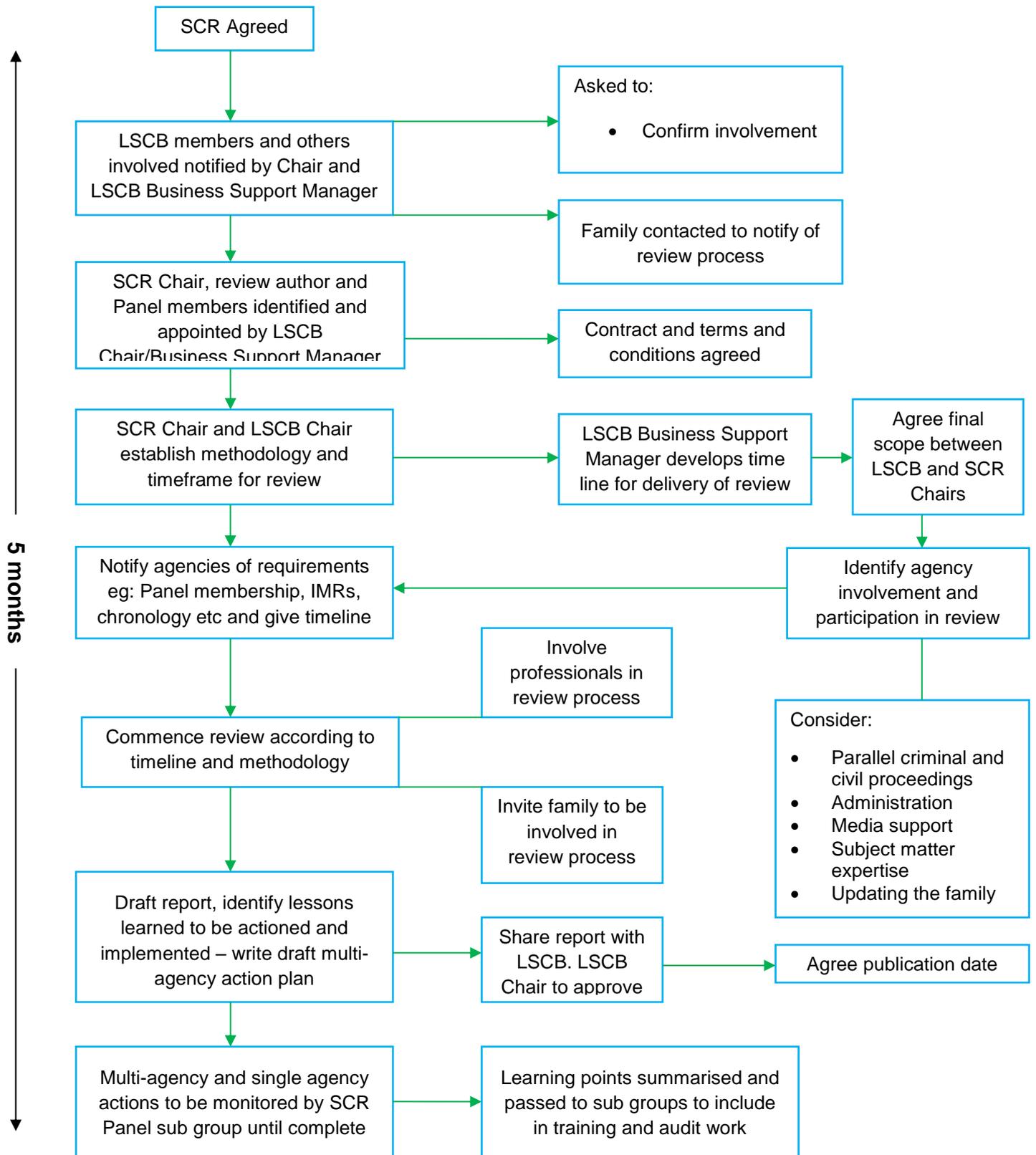
**Your agency information will be used by the Serious Case Review (Sub Group) of the LSCB and will be stored and shared in accordance with the LSCB partner agency information governance agreement.**

**PLEASE NOTE IF YOU HAVE ANY CONCERN ABOUT COMPLETING THE ATTACHED FORM PLEASE CONTACT LESLEY HUTCHINSON**

### Appendix 3: Serious Case Review Consideration and Decision

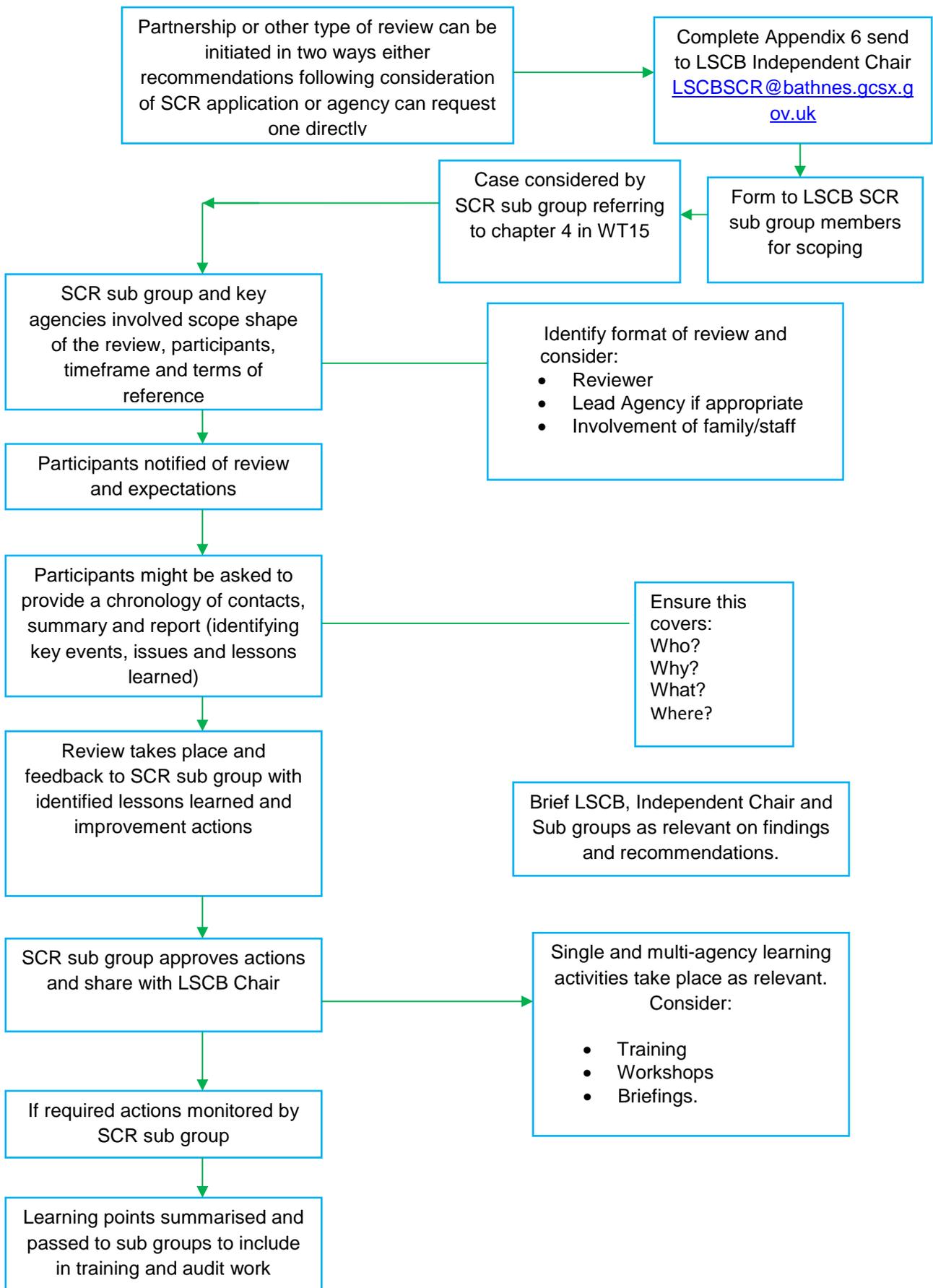


## Appendix 4: Serious Case Reviews



The LSCB should aim for completion SCR within 6 months of initiating

## Appendix 5: Partnership or Other Type of Multi-Agency Review





**5. Reason for Requesting a Multi-Agency Review**

Please explain clearly why you believe a multi-agency would be of benefit?

Please continue on a separate sheet if necessary)

**PLEASE RETURN THIS COMPLETED FORM TO:**  
 Bath and North East Somerset LSCB:  
[LSCBSCR@bathnes.gcsx.gov.uk](mailto:LSCBSCR@bathnes.gcsx.gov.uk) and title your email 'Confidential SCR referral FAO LSCB Chair and SCR sub group Chair'

For Office Use:	
Data received by SCR sub group Chair	
Date discussed SCR sub group	
Brief overview of issues for LSCB Chair to consider	
Recommendation made by sub group to Chair of LSCB	
Progress with a multi-agency review	Yes or No
Type of Review Recommended:	
Chair of SCR sub group:	
Signed .....	Date .....
LSCB Chair comments on the above recommendation:	
Signed .....	Date .....

## **Appendix 7: Serious Case Review checklist / guidance**

### **Notification**

The LSCB should let Ofsted, DfE and the National Panel of Independent Experts know their decision within five working days of the Chair's decision.

If the LSCB decides not to initiate an SCR, their decision will be subject to scrutiny by the National Panel. The LSCB should provide sufficient information to the Panel on request to inform its deliberations and the LSCB Chair or the Chair's representative should be prepared to attend in person to give evidence to the Panel. In cases where an LSCB is challenged by the National Panel to change its original decision, the LSCB should inform Ofsted, DfE and the National Panel of the final outcome.

### **Appointing reviewers**

The LSCB must appoint one or more suitable individuals to lead the SCR who have demonstrated that they are qualified to conduct reviews using the approach set out in this guidance. The lead reviewer / Chair of the review should be independent of the LSCB and the organisations involved in the case. The LSCB should provide the National Panel of Independent Experts with the name(s) of the individual(s) they appoint to conduct the SCR. The LSCB should consider carefully any advice from the Independent Expert Panel about appointment of reviewers / chairs / authors.

### **Engagement of organisations**

The LSCB should ensure that there is appropriate representation in the review process of professionals and organisations who were involved with the child and family. The priority should be to engage organisations in a way which will ensure that important factors in the case can be identified and appropriate action taken to make improvements. The LSCB may decide as part of the SCR to ask each relevant organisation to provide information in writing about its involvement with the child who is the subject of the review.

### **Timescale for SCR completion**

The LSCB should aim for completion of an SCR within six months of initiating it. If this is not possible (for example, because of potential prejudice to related court proceedings), every effort should be made while the SCR is in progress to: (i) capture points from the case about improvements needed; and (ii) take corrective action to implement improvements and disseminate learning.

### **Agreeing improvement action**

The LSCB should oversee the process of agreeing with partners what action they need to take in light of the SCR findings, establish timescales for action to be taken, agree success criteria and assess the impact of the actions.

## **Publication of reports**

All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.

### **Final SCR reports should:**

- provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- be suitable for publication without needing to be amended or redacted.

LSCBs should publish, either as part of the SCR report or in a separate document, information about: actions which have already been taken in response to the review findings; the impact these actions have had on improving services; and what more will be done.

When compiling and preparing to publish reports, LSCBs should consider carefully how best to manage the impact of publication on children, family members and others affected by the case. LSCBs must comply with the Data Protection Act 1998 in relation to SCRs, including when compiling or publishing the report, and must comply also with any other restrictions on publication of information, such as court orders. The timing of publication should have due regard to the impact on any ongoing legal proceedings, including any inquest.

LSCBs should send copies of all SCR reports, including any action taken as a result of the findings of the SCR, to Ofsted, DfE and the National Panel of independent experts at least seven working days before publication. If an LSCB considers that an SCR report should not be published, it should inform DfE and the National Panel. The National Panel will provide advice to the LSCB. The LSCB should provide all relevant information to the Panel on request, to inform its deliberations. In cases where an LSCB is challenged by the Panel to change its original decision about publication, the LSCB should inform Ofsted, DfE and the National Panel of their final decision.