

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURE ON SERIOUS CASE REVIEWS

1.0 INTRODUCTION

- 1.1 This procedure sets out the requirements for the Trust and staff to comply with *Working Together to Safeguard Children 2015*, and Local Safeguarding Children Board Procedural Guidance
The Local Safeguarding Children Board (LSCB) is responsible for instigating a Serious Case Review (SCR).

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.

A serious case is one where:

- Abuse or neglect of a child is known or suspected; and either —
 - The child has died ; or
 - The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.
- 1.2 A SCR should also be considered whenever a child has been seriously harmed in the following situations:
- A potentially life-threatening injury;
 - Serious impairment at the time of the incident, and/or 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.

- 1.3 When the LSCB instigates a Serious Case Review a Trust Individual Management Review (IMR) or alternative review, e.g. a Multi-Agency Review (MAR) methodology will be agreed if the child or parent/carer is known or has been known to the Trust. The aim of the Individual Management Review or alternate Multi-Agency Review methodology is to look openly and critically at individual and organisational practice to identify:
- Areas of good practice;
 - Whether the case indicates changes could and should be made;
 - How these changes will be brought about and monitored.
- 1.4 The findings and analysis from the review will be brought together by the LSCB SCR Panel with other agencies/organisations into an 'Overview Report'.
- 1.5 The Trust will be expected to implement specific recommendations by the LSCB, regardless of whether the Trust is directly involved in the case

2.0 PURPOSE OF SERIOUS CASE REVIEWS

- 2.1 Establish whether there are lessons to be learned from a case about the way in which local professionals and agencies work together to safeguard children.
- 2.2 Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
- 2.3 Improve inter-agency working and better safeguard and promote the welfare of children.
- 2.4 SCR's are not inquiries into how a child died or who is culpable. These matters are for Coroners and Criminal Courts respectively.
- 2.5 When there is a death or serious injury of a child and abuse or neglect are suspected to be factors in that death an assessment should be undertaken of whether there are other children in the household/family who require safeguarding.

3.0 PROCESS

- 3.1 Once it is known that a child/young person has died, or a case is being considered for a Serious Case Review the Associate Director for Safeguarding will inform the Serious Incident Team (in order to reduce duplication of any parallel process) and the Executive Director for Clinical Governance
- 3.2 The Trust Named Nurse/Practitioner Safeguarding Children will secure all relevant adult and child records.
 - The records will be copied with the originals being kept by the Safeguarding Team and copies returned to the practitioner. On completion the originals will be returned to the practitioner.
 - In the case of a child being taken into care the record should be forwarded on to the appropriate health professional where the child is residing.
 - In the case of a Looked After Child, a copy of the records are forwarded on to the Named Nurse Safeguarding Children where the child is residing.
- 3.3 The Designated Nurse for the relevant CCG should inform NHS Midlands and East and the Care Quality Commission of every case that becomes subject of a SCR within one month of the LSCB agreeing that a SCR should take place.
- 3.4 The Trust Chief Executive will receive notification from the Local Safeguarding Children Board (LSCB) of the Serious Case Review, and will be asked to nominate a Reviewing Officer to undertake the Individual Management Review (IMR). Reviewing officers will be supported by a member of the Safeguarding Team

- 3.5 Where a case involves a number of Trust services e.g. Community Health and Mental Health services, only one IMR will be required. Where it is deemed appropriate, separate IMR's maybe agreed. The Reviewing Officer will co-ordinate the collection of records and liaise with other relevant Named Safeguarding Nurses/Practitioners as required.
- 3.6 The Reviewing Officer will review all case records on the child/children in order to:
- Complete a comprehensive, factual chronology of involvement by the professionals in contact with the child/children as set out in the SCR's terms of reference.
 - To compile a report which looks openly and critically at the involvement of professionals/services and contains analysis of the presenting facts.
 - Develop a SMART action plan.
 - Identify any omissions in the Trust or LSCB Child Protection /Safeguarding Children Policies or Child Health Procedures.
- 3.7 The review report will be completed within the set timescales as stated in the terms of reference/scoping (usually one calendar month from the request).
- 3.8 Staff involved in the case may need to be interviewed by the Reviewing Officer using the LSCB interview format. A copy of the interview summary should be given to the interviewee.
- 3.9 The Reviewing Officer should ensure that appropriate support and supervision is offered to staff and interviewees.
- 3.10 The Individual Management Report will be submitted to the Trust Safeguarding Group and Executive Team in order that it is ratified by the Trust Chief Executive.
- 3.11 The Trust Associate Director for Safeguarding will liaise with the Trust Communications department as necessary.
- 3.12 Any recommendations made in the IMR will be placed on the Trust Safeguarding Group action plan and can be implemented as soon as possible. Any subsequent recommendations made from the LSCB will also be placed on the action plan and monitored monthly for compliance.
- 3.13 Once the Individual Management Report has been submitted to the LSCB a feedback process and debriefing for staff involved should take place, which may be before the completion of the final report by the LSCB.
- 3.14 Where the LSCB commissions an alternative case review methodology, the Trust should co-operate to influence and agree the terms of reference.
- 3.15 Trust staff will be required to participate in appropriate learning events as part of the agreed commissioned case review and will be supported by their own operational managers and the Trust Safeguarding Children Named Nurse/Professionals.

- 3.16 A summary of the outcomes and recommendations of the final interagency SCR Overview Report from the LSCB will be presented to the Trust Safeguarding Team and reported to the Executive Team as required.
- 3.17 Serious Case Reviews are not part of any disciplinary enquiry or process, but information that emerges from the Individual Management Review or alternative case review methodology could indicate that actions may be required, including disciplinary action.
- 3.18 The Full Overview Report compiled by the LSCB will be available to the public via the LSCB Website. The Safeguarding Annual report will contain details of any SCR that the Trust has involvement with.
- 3.19 Implementation of Trust Action plans as part of the IMR or Overview report will be the responsibility of the Director of the Service/s involved in the case.
- 3.20 The implementation will be monitored via relevant service management, Community Services Safeguarding Children Groups and the Trust Safeguarding Children & Adult Group.

END
