Case Review and Governance subgroup operating principles and guidance on reviews

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1. Introduction

This paper sets out the current reference points available to assist the subgroup in determining how best to manage serious case reviews. It includes preferred process and methodology, the role of the panel, the involvement of families, parallel processes and consequences thereof, information sharing, final reports as well as learning and improvement.

2. Context

The Case Review and Governance (CRAG) subgroup oversees all serious case reviews (SCR). The remit of the LSCB is set out in Working Together to safeguard children. This includes the completion of serious case reviews on the basis of the below criterion:

> *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.*

In Oxfordshire the CRAG has oversight of the serious case review process from beginning to end. This work is reported in to and supported by the LSCB's Independent chair of the board and reported to the Board on an annual basis for scrutiny.

Undertaking a serious case review

3. Process

- Reviews must be conducted as promptly as possible to maximise the relevance and impact of learning for agencies
- SCRs are regarded with seriousness and trepidation by staff and managers. Being amongst the practitioners for a child who has died or been seriously injured is a source of anxiety for staff and the process should have regard for their welfare as well as the welfare of the child's family and friends.
- The CRAG chair will keep the independent chair of OSCB regularly appraised of the progress of SCRs, the timescale for completion and the key themes and findings.
- The OSCB business manager acts as the main point of contact between the reviewer and the OSCB, facilitating the reviewer's contact with the CRAG and the independent chair as necessary.

4. Methodology

- Individual agency chronology and self-analysis must be part of all reviews, as well as analysis of the effectiveness of the system. The scope of the chronology and analysis will be determined in each review.
- There is not one methodology that is best for all cases. Once a decision has been made by the independent chair to conduct a review, the CRAG is responsible for ensuring an appropriate approach is employed and a suitable reviewer is appointed to deliver the review.
- The methodology should include the contributions of family/friends of the subject(s).
- Consideration must be given to whether/how frontline practitioner events can add value to the review and improve engagement of the services in learning.
- Reviews must address the reasons why actions were taken/not taken ie the conditions and factors that drove the practice, as well as individuals' responsibilities.

5. Role of the review panel and of panel members

The serious case review panel comprises the reviewer and agencies contributing to the review process. The panel works with the reviewer for the duration of the review.

The panel will help set the scope of the review, the key questions to be addressed and support the reviewer in the conclusion of their findings.
The panel members act as an agency /service representative for the serious case review. Panel members are essential at all points in the review and are pivotal to the smooth completion of the work.
The panel members ensure that key decisions from the panel meeting are relayed back; that managers are sighted on the review: its time frame, progress, findings, recommendations and associated actions; that senior managers sign off all key documents; that key stakeholders within that agency are sighted on the final report for the review and its findings to sign it off. That the communications leads are sighted on the review publication and are linked in to the development of a communications plan for publication.

The contact with the review for panel members is through the business unit.
A full role descriptor for panel members is set out at Appendix A.

6. Role of a panel member linking to another agency

Agencies contribute to the review because they have had involvement with the subject of the review. On occasion this involvement may be minimal. When this is the case there is no need for the agency representative to become a full member of the panel. Instead another member of the panel will be nominated to link back to that agency and keep them informed of the review for the duration.

The linked panel member has additional responsibilities to those outlined above. They should ensure that the service /agency is fully aware of:

- Time frames
- Required actions
- Submission deadlines
- Any changes e.g. timeframes, details, personnel or terms of reference
- Report drafts
- Final report sign off
- Action plan sign off
- Learning summary sign off

- Dissemination of findings and learning summary across their agency
- Communications plan
- Publication date and plans

7. Involvement of family members

Notification to family members and any other key parties at the start of the review should be co-ordinated and recorded. A clear communication plan should be in place for the family, which is co-ordinated, as required, across agencies. This should be overseen by the reviewer and the review panel.

When there are parallel investigations/reviews being conducted concurrently it is important to ensure not only that the family is fully involved at the earliest appropriate opportunity in relation to the individual process but also that the family is not contacted on multiple occasions by different organisations at different times, which might be distressing and/or discourage the family from taking part in the process.

The timing of the contact with the family will be dependent on the interplay between the concurrent processes e.g. where there is a serious case review and an ongoing criminal investigation there may be compelling reasons not to contact the family if the integrity of evidence may thereby be compromised. The decision on the right time to contact the family, and by whom, will be made through liaison between the Chairs/Overview authors of the concurrent processes (and in particular through liaison with the police) with the Overview Author of the serious case review taking the lead through whom the information is co-ordinated. In the event of lack of agreement or uncertainty the chair of CRAG should contact OCC's Legal Services.

- Notification to key parties, including the family, is co-ordinated
- There is a clear communication plan with the family as required going across agencies and a lead for the plan is identified.

8. Possible parallel processes

There are a number of parallel processes that the CRAG should be mindful of in the oversight of all serious case reviews: disciplinary proceedings, criminal proceedings,

complaints or other professional proceedings such as coroner inquests, internal investigations such as serious incident investigations or other formal reviews such as domestic homicide reviews or Independent Investigations following an mental health related homicide

8.1.Disciplinary processes

Disciplinary processes should not be a barrier to a serious case review and are separate from the process. They may impact on the ability of a reviewer to meet with practitioners or, if an individual management review is being completed, on the ability to complete the report if the outcome of the process is likely to shape the findings of the review. The CRAG should ensure that:

- All agencies involved in the serious case review, as contributors either on the panel or with a link member on the panel, should disclose if disciplinary processes are instigated at any point and keep the panel informed about progress or any barriers to completion of the report.

8.2.Criminal proceedings

A criminal investigation should not be a barrier to a serious case review capturing the learning required to safeguard children now and in the future. The College of Policing sets outs its authorised professional practice at the attached link:
http://www.app.college.police.uk/app-content/major-investigation-and-public-protection/homicide/

The Crown Prosecution Service produced guidance in May 2014 to help the serious case review process and criminal investigation to continue in parallel and in particular to help parties work through any potential contentious points for example when the SCR author can interview family members. The guidance can be found at the following link:
http://www.cps.gov.uk/publications/docs/liaison_and_information_exchange.pdf

It provides a framework and guiding principles with respect to: process; timescales; potential witnesses; terms of reference of the review; disclosure and sharing of material generated by the SCR. The guidance includes a flow chart which is clear that:

- On commencement of a serious child abuse investigation by the police the senior investigating officer should make early contact with the Police LSCB representative. This should lead to a discussion with the SCR Reviewer and panel with respect to the terms of reference and information sharing.

The CRAG should ensure that:

- Communication between the police investigation and the case review should be ongoing, prompt and supportive of both processes.
- This CPS guidance is robustly and actively used as CRAG's reference point to support parallel processes and ensure swift completion of reviews

8.3.Complaints: Agency complaints procedures

Agency complaints procedures should not impede the progress of a serious case review and are separate from the process. A serious case review is not a complaints process and the Reviewer and reference panel should ensure that this is understood by all parties, in particular family members, where the review may be regarded as a means to deal with specific concerns. The CRAG should ensure that:

- SCR Reviewer and panel produce terms of reference which are clear as to the remit of the review and which would not extend to managing complaints.
- Communication with all parties, in particular family members should manage expectations on this and ensure that all parties are clear about how to make a complaint as a separate process.

- **Complaints: Independent Police Complaints Commission (IPCC)**

The IPCC oversees the police complaints system in England and Wales and sets the standards by which the police should handle complaints. They are independent and make their decisions entirely independently of the police and government. They are not part of the police. The CRAG should ensure that:

- The TVP representative informs the CRAG at the earliest opportunity of an IPCC investigation
- The Reviewer / Chair makes early contact with the IPCC to be clear on the remit of their work, timescales and affected parties
- Any findings pertinent to the review are shared with the Reviewer as appropriate

8.4.Professional proceedings:

- **Coroner** – the Coroner has its own independent process which seeks to determine the cause of any sudden or unnatural death. The coroner's jurisdiction is limited to determining who the deceased was and how, when and where they came by their death. Good working relationship between the CRAG in overseeing case reviews and Coroner should include:
  - Notification to the OSCB of any sudden or unnatural child death at the same point of notification to the Child Death Overview Panel
  - The circulation of any local coroner reports concerning the prevention of future deaths to the CRAG and Child Death Overview Panel to ensure that learning is shared
  - Contribution to the Child Death review process and the annual report of the Child Death Overview Panel which informs the learning and improvement framework of the OSCB

As appropriate this should be shared with the Reviewer.

- **Serious incident requiring investigation by health settings**

The revised NHS England 'Serious Incident Framework' published in March 2015 builds on previous guidance that introduced a systematic process for responding to serious incidents in NHS-funded care. This states that '*The interface between the serious incident process and local safeguarding procedures must therefore be articulated in the local multi-agency safeguarding policies and protocols. Providers and commissioners must liaise regularly with the local authority safeguarding lead to ensure that there is a coherent multi-agency approach to investigating and responding to safeguarding concerns, which is agreed by relevant partners. Partners should develop a memorandum of understanding to support partnership working wherever possible'*. The NHS guidance for serious incidents can be accessed at the following link: https://www.england.nhs.uk/patientsafety/serious-incident/

Carrying out a serious incident investigation should not be a barrier to the completion of a child serious case review. The Root Cause Analysis investigation report carried out into a serious incident about the same incident or death as the child serious case review investigation can be used as an equivalent individual management review (IMR) by the health agency.

- On commencement of an internal safeguarding review of a serious incident the agency safeguarding lead should inform relevant parties including the safeguarding board representative and safeguarding board business unit
- The key findings should be shared with the Reviewer as appropriate
- A root cause analysis (RCA) required for a serious incident investigation can be used as the basis for an IMR to prevent delays in organisational learning and to meet NHS England serious incident processes requirements.
- Any single agency serious incident which includes a safeguarding element will be reported to CRAG by the organisations representative in order to discuss any multi-agency learning opportunities.
- Learning and key findings will be shared as appropriate.

- **Agency management reviews**

An internal management review will not hold the same legal status as a serious case review but will impact on the service and lead to learning that could be of value to the serious case review. Guidance attached at Appendix A includes the 'Community Safeguarding and Public Protection Incidents (CSPPI)' for the Youth Justice Service and the critical incident process for Children's Social Care. These should not be a barrier to the completion of a serious case review.

- On commencement of an internal safeguarding review of a serious incident the safeguarding lead should inform the OSCB CRAG representative
- The key findings should be shared with the Reviewer as appropriate

8.5.Other formal reviews e.g. Domestic Homicide Review, Safeguarding Adults Review, Mental Health Homicide Reviews

It is possible that a serious incident may meet the criteria for more than one review e.g. Domestic Homicide Review, Safeguarding Adults Review, serious incident investigation. See the embedded document at Appendix B with a short summary of how these different reviews compare.

There is Multi-agency statutory guidance for the conduct of domestic homicide reviews (DHRs). A Mental Health Homicide Review does not have multi-agency guidelines but the framework for reference is the NHSE serious incident framework.

The DHR guidance outlines: the purpose of a domestic homicide review; conducting a review; involving families and friends; the importance of having a representative review panel. The Department of Health recognises that domestic homicide reviews have a strong parallel with child Serious Case Reviews and serious incident investigations and the guidance states that Community Safety Partnerships should establish the existence of any other ongoing reviews, such as a child Serious Case Review (SCR), which will need to be considered as part of the decision to undertake an independent homicide review. In many cases the serious incident investigation completed by the health agency will be used to inform the terms of reference of the multi-agency homicide review.

When victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for child Serious Case Reviews, Safeguarding Adults Review and a Domestic Homicide Review. Consideration should be given to how these reviews can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case – for example, considering whether some or all aspects of the reviews can be commissioned jointly so as to reduce duplication of work for the organisations involved and provide an improved experience for families, subject to the final shape of the review meeting the requirements of both as set out in the statutory guidance. The CRAG has experience of overseeing a combined serious case review / domestic or mental health homicide and of linking to a local domestic homicide where the case had not quite met the criteria for a serious case review.

Similarly there is guidance for Safeguarding Adult Reviews.

In all cases of overlap the CRAG should ensure that:

- Communication between the OSCB and the other lead partnership is ongoing and supportive to decision making
- Communication between any subsequent domestic or mental health homicide panel or Safeguarding Adults Review should be ongoing, prompt and supportive of both processes.
- Notification to key parties, including the family, is co-ordinated
- There is a clear communication plan with the family as required going across agencies and a lead for the plan is identified.

- Practitioners understand that there are a number of review processes; know what they are and are informed of any implications regarding information that they submit
- Reviewers for parallel processes are working in a supportive way; terms of reference are shared; information is shared appropriately to avoid duplication; implications for practitioners are considered e.g. practitioners need only be interviewed once if they give their consent to their interview notes being used by both processes
- This relevant guidance with appendix B is actively used as a reference point to support parallel processes and ensure swift completion of reviews

8.2. Ownership of reports and information

The ownership of reports and sharing of information should be carefully managed. In the event of lack of agreement or uncertainty the chair of CRAG should contact OCC's Legal Services.

Appendix A

Role of the panel member

Initiation of the review

1. Act as an agency /service representative for the serious case review.
2. Inform the review of any parallel processes that you are aware of e.g. investigations, professional or legal proceedings.
3. Support the SCR reviewer by helping to scope the review, contribute to analysis, provide constructive comments on the draft report and shape the recommendations.
4. Advise the review of the name / contact details for the author of the chronology.
5. Act as a link for the development of the chronology and any associated report and be able to talk and comment on the content.
6. As appropriate advise of any connection with the subject or family which can assist with smooth communications regarding the review

Progression of the review

7. Attend panel meetings. If unable to attend the meeting arrange for a 'briefed' deputy to attend with any comments that you have or contact the reviewer to provide feedback directly.
8. Prepare for all meetings by allocating the time to read papers, check details relevant to your agency and ensure factual accuracy
9. Support the reviewer by helping set up interviews with practitioners in your agency: identifying and contacting colleagues, attending interviews and commenting on their outcome

Completion of the review

10. Support the reviewer by helping set out a short number of recommendations
11. Work with OSCB partners to develop an action plan for the implementation of recommendations
12. Review the learning summary for the review.

13. Support the communications plan for publication.
14. Ensure dissemination of findings and learning summary across their agency

Linking back to the agency/ service throughout:

15. Ensure that key decisions from the panel meeting are relayed back to your agency / service and that any required actions are completed in a timely manner.
16. Ensure that senior managers within your agency are sighted on the review: its time frame, progress, findings, recommendations and associated actions.
17. Ensure that senior managers sign off **all key documents** e.g. chronologies, individual management reviews, the final report, action plan and learning summary.
18. Ensure that senior managers, leaders and stakeholders within your agency e.g. councillors, governors or board members are sighted on the final report for the review and its findings in order to sign it off.
19. Ensure that your communications leads are sighed on the review publication and are linked in to the development of a communications plan for publication.

Acting as a link to another agency

20. Colleagues nominated to act as a link to another service / agency have the same role and responsibilities as outlined above. In particular, you should ensure that the service /agency is fully aware of:
    - Time frames
    - Required actions
    - Submission deadlines
    - Any changes e.g. timeframes, details, personnel or terms of reference
    - Report drafts
    - Final report sign off
    - Action plan sign off
    - Learning summary sign off
    - Dissemination of findings and learning summary across their agency
    - Communications plan

- Publication date and plans

Appendix B

Summary of actions in relation to parallel processes

This guidance should be used robustly so that child serious case reviews are carried out as expeditiously as possible without adverse impact on other processes or families or staff being interviewed

In the case of **disciplinary** proceedings CRAG should ensure that:

- All agencies involved in the serious case review, as contributors either on the panel or with a link member on the panel, disclose if disciplinary processes are instigated at any point and keep the panel informed about progress or any barriers to completion of the report.

In the case of **criminal** proceedings CRAG should ensure that:

- The TVP representative informs the CRAG at the earliest opportunity
- The Reviewer, Chair , panel are informed of potential criminal investigation and conflict of interest in membership is avoided
- The Reviewer / Senior Investigating Officer maintain ongoing contact throughout
- The contributing practitioners are made aware of the criminal processes and potential impact on statements made / about to made in terms of the review process
- Agencies producing information are aware of the criminal processes and the legal representative to CRAG advises on the ownership of information
- The CPS guidance is robustly and actively used as CRAG's reference point to support parallel processes and ensure swift completion of reviews

In the case of **complaints** processes including IPCC

- Agency representatives on the CRAG are clear of their duty to inform the subgroup, keep it updated on progress and outcomes relative to the review

- The reviewer makes early contact with the IPCC to be clear on the remit of their work, timescales and affected parties
- Any findings pertinent to the review are shared with the Reviewer as appropriate

In the case of **professional** proceedings the CRAG requests that:

- The Coroner notifies the OSCB of any sudden or unnatural child death at the same point of notification to the Child Death Overview Panel
- On commencement of an internal safeguarding review of a serious incident the safeguarding lead should inform the OSCB CRAG representative - key findings should be shared with the Reviewer as appropriate
- On commencement of a professional review CRAG representatives should ensure that the Chair is informed
- Communication between the OSCB and the other lead partnership is ongoing, supportive to decision making and helpful to both processes.
- Guidance is actively used as a reference point to support parallel processes and ensure swift completion of reviews

In the case of **serious incident investigation** processes:

- Agency representatives on the CRAG are clear of their duty to inform the subgroup, keep it updated on progress and outcomes relative to the review
- The commissioner is kept informed of progress with the SI investigation
- The report from the SI investigation is shared by the agency, as appropriate, to support the other investigation processes and to avoid duplication. The initial report and root cause analysis report from the SI investigation will be used as an equivalent IMR for the agency and may help to inform the terms of reference of wider multi-agency reviews.
- In the case of Mental Health Homicide Investigations the provider and CCG representatives have a duty to inform the CRAG of the commissioning and progress of Independent Investigations

Appendix C

Service / review type	Information source
Police	http://www.app.college.police.uk/app-content/major-investigation-and-public-protection/homicide/
Crown Prosecution Service	http://www.cps.gov.uk/publications/docs/liaison_and_information_exchange.pdf
Independent Police Complaints Commission (IPCC)	IPCC
NHS England 'Serious Incident Framework'	https://www.england.nhs.uk/patientsafety/serious-incident/
Children's Social Care, County Council	 Critical Incident Reviews CSC procedu
Youth Justice Service, County Council	Community Safeguarding and Public Protection Incidents (CSPPI) – Standard Operating Procedures for Youth Offending Teams
Safeguarding Adult Reviews	Safeguarding Adult Reviews
Domestic Homicide Reviews	Multi-agency statutory guidance for the conduct of domestic homicide reviews.

Case reviews	 Key Features of Serious CRs (2).pdf

	This document was forwarded from NHS England for use by CRAG.