Safeguarding Partnership Board
Serious Case Review Procedures

Document profile

Document Status	REVIEW
Short Title	**SCR Procedures (Joint)**
Document Purpose	Multi-agency procedures for dealing with Serious Case Reviews in Jersey
Target Audience	Staff in statutory departments and non-government agencies who work with children in Jersey
Author	SPB Independent Chair
Publication Date	2nd March 2015, reviewed September 2016
Review Date	March 2018
Approval Route	SCR SG and SPB
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Contents

1. Introduction

1.1 The Safeguarding Partnership Board (SPB) is the multi-agency body responsible for advising the States of Jersey on safeguarding issues concerning children or adults at risk. The SPB ensures that arrangements are in place to enable services and professionals to work effectively together.

1.2 The SPB has a number of specific roles to play in safeguarding and protecting children and adults; these are to:

a. co-ordinate what is done by each organisation participating in the Boards for the purposes of safeguarding and promoting the welfare of children and adults in Jersey;

b. promote understanding of the need and means to protect children and adults from harm; and

c. monitor and ensure the effectiveness of the safeguarding systems that are in place both within and between organisations in Jersey.

2. Reviews

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2.1 There are different types of review which include:

- Serious Case Reviews for every case that meets the criteria in paragraph 4
- child death reviews which look at all child deaths up to the age of 18 to identify trends and learning. These will be undertaken by the Jersey and Guernsey Child Death Overview Panel which acts as a Subgroup of the SPB
- reviews of an adult or child protection incident which falls below the threshold for an SCR; and
- reviews or audits of practice in one or more agency; these will be undertaken by a single agency or by a number of organisations working together.

When undertaking 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 and adults, the SPB will follow the principles in this guidance.

3. Serious Case Reviews

3.1 SCRs are an integral part of the SPB as a learning organisation; their purpose is to identify learning and good practice. Professionals and organisations protecting/safeguarding children and adults should reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.

3.2 These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Safeguarding Boards in England, Wales and N Ireland have an interest in understanding both what works well and also why things can go wrong.

3.3 The SPB will commission SCRs in respect of children and adults and advise the individuals and organisations on lessons to be learned and monitor the implementation of recommendations.

3.4 There are clear criteria (see paras. 4.3 and 4.4) for undertaking SCRs but the SPB has the authority to conduct an SCR when the criteria are not met.

3.5 SCRs are about public accountability, they are not about apportioning blame or culpability.
They not part of any disciplinary process relating to an individual. Where information emerges in the course of a SCR indicating that disciplinary action or any other Human Resources process should be initiated, this will be addressed separately from the SCR under established Human Resources procedures.

3.6 Similarly SCRs are not inquiries into how a child or an adult at risk died or was seriously harmed, or who is/may be culpable. These are matters for the Viscount's Office/criminal courts to determine as appropriate.

3.7 These procedures will be reviewed and amended over time as the SPB learns from its own experience and that of others.

4. Procedure for referring an SCR for consideration

4.1 The decision to undertake an SCR is the responsibility of the Independent Chair of the SPB who will consider the referral for an SCR with the SCR Subgroup and record this using Appendix 3 and report his/her decision to the SPB and the referrer.

4.2 Referrals for SCRs can come from any professional or partner agency or other interested parties, if they believe that there are important lessons for inter-agency working; these should be made in writing to the Independent Chair of the Safeguarding Partnership Board using the referral forms (Appendix 2)

4.3 The criteria for conducting a **SCR for adults** are as follows:

The SPB will arrange for there to be a review of a case involving an adult in Jersey with needs for care and support (whether or not services have been meeting any of those needs) if -

(a) there is reasonable cause for concern about how the SPB, members of it or other persons with relevant functions worked together to safeguard the adult, ***and***

(b) condition 1 or 2 is met.

- *Condition 1 is met if - (a) the adult has died,* ***and*** *(b) the SPB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).*
- *Condition 2 is met if - (a) the adult is still alive,* ***and*** *(b) the SPB knows or suspects that the adult has experienced serious abuse or neglect*[1].

4.4 The criteria for conducting a **SCR for Children** are as follows:

The SPB will arrange for there to be a review of a case involving a child or young person in Jersey if -

(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.

Cases which meet one of these criteria will **always** trigger an SCR. In addition, even if one of these criteria are not met an SCR **should always** be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution or a secure children's home or where a child died by suspected suicide.

5 Initiating a Serious Case Review

5.1 Where the Chair of the SPB receives a referral for consideration, s/he will bring this to the attention of the SCR sub-group for discussion.

[1] Care Act 2014

5.2 The Independent Chair has a range of options available as outcomes when considering a referral with the SCR Sub Group, including:

a. Commission an SCR
b. Undertake a Partnership Review
c. Request single agency audits/reviews
d. No further action

5.3 The Chair of the SPB has the responsibility and authority for deciding whether to conduct a SCR and will identify an Independent Chair of the SCR Panel to manage the SCR process and identify an Independent Overview Author to produce the final report which should be suitable for publication. The proposed author will provide a CV. The names of these people will be shared with the SCR Subgroup before they are appointed. The Chair of the SPB will ensure the contracts for the Independent Panel Chair and Overview Author for the SCR are formally agreed.

5.4 In the event that a child or an adult dies the Independent Chair will notify the Viscount's office of the commissioning of an SCR.

6 Consents

6.1 Data Protection (Jersey) Law (2005) requires that consent is obtained from the data subject before sharing of personal sensitive data with some exceptions.

6.2 The '**Data Protection Principles[2]'** contained with the 2005 law are to be adhered to when handling personal identifiable data. When information is shared the '**Caldicott principles for professional standards and good practice** (2013)'[3] are to be applied

6.3 **Adults:** Consent from adults with capacity should be sought and secured before access to their medical records commences. If access is refused the request should not be repeated. Care must be taken to ensure the most appropriate and trusted agency representative makes the request. Children are presumed able to consent from 16 years.

6.4 **Children < 18 years:** Where a child is under the age of 18 there is an expectation that information will be shared in the interests of safeguarding. Alternatively, a person with

[2] ***Data Protection Principles*** *(2005) available in Data Protection Jersey (2005) Law* *http://www.jerseylaw.je/Law/display.aspx?url=lawsinforce%2fconsolidated%2f15%2f15.240_DataProtectionLaw2005_RevisedEdition_1January2012.htm*

[3] ***Caldicott principles for professional standards and good practice*** (2013). http://hssnet/Registered%20Documents/Policies/General%20Policies/HSS-PP-IG-0115-03%20Data%20Protection%20Policy.pdf

parental responsibility can consent or the young person can consent for themselves if they are believed to be 'Gillick Competent.'

6.5 **Where an individual may lack capacity:** If it is determined that the individual does not have the capacity to consent for themselves (see SPB Multi Agency Capacity Policy) then 'best interests' processes for decision making must be followed.

6.6 **Deceased individuals:** A common law duty of confidence remains with the deceased. Decisions regarding sharing of information will be made on an individual basis with the person's representatives considering what is in the public interest.

6.7 **In the case of an SCR in relation to a child who is the subject of a Care Order:** Before the review commences, the SPB Chair, through the Minister of Health, will apply to the court for the disclosure of any relevant documents submitted in support of the Care Order application. The court will seek the views of all those who were party to the care proceedings in reaching a decision.

6.8 If the court consents to the request, there will be strict adherence to the directions of the court in respect of how the documents will be handled.

7 Involvement of child or adult and family / significant others

7.1 Following the decision to conduct an SCR, the subject, if appropriate, and family members will be informed of the decision to conduct a review by the SPB chair so that they are aware of the process and purpose and the principle of publication. Whilst the agreement of the subject or the family is not required, the SCR will be more easily achieved with their support and co-operation. Family involvement has the potential to make an important contribution to the learning from SCRs Each SCR will be considered individually in relation to the principles of clarity, transparency, negotiation and inclusivity.

Four phases of family involvement should be considered:
Phase One: initial contact and information about review (purpose, remit, and relationship to other processes), identification of any specific support needs of family including use of interpreters and advocates.
Phase Two: negotiation (where possible) of Terms of Reference, agree type and process of involvement, mapping of family members to be involved, facilitation of family preparation including setting out how family information will be used.
Phase Three: substantive gathering of information, including family descriptions of experiences, agreement about ongoing contact and feedback arrangements.

Phase Four: feedback, fulfilling appropriate commitments concerned with reporting actions and change.

7.2 It is essential that the subject/family and relevant others are kept informed of the progress of the review and have the opportunity to talk to the Overview Author to communicate their views of the services they received. Before the Overview Report is completed it will be shared with the subject/family/relevant others for their comment, their views in respect of publication of the report will be taken very seriously.

7.3 If the report is to be published the above parties will be informed of the date and where the report will be placed (e.g. on the SPB website) and provided with a copy.

If a family member refuses involvement with a review , a discussion with the overview author and independent Chair of the SPB will happen and decision reached as to future communication and for this decision to be recorded.

8 Serious Case Review Methodology

8.1 There are several ways of undertaking SCRs. In determining which approach to use the following principles will be followed.

8.2 SCRs should be:

- Timely – priority will be given to meeting the agreed timescales so that they can be completed in six months
- Impartial and objective – the SCR will be conducted fairly and impartially
- Thorough – the SCR process will explore each of the terms of reference in detail
- Open and transparent – the review and its outcomes should be shared, including publication where appropriate
- Confidential – all information gathered throughout the process will be treated as confidential and will only be shared or disclosed when/if appropriate to do so
- Proportionate – taking account of the circumstances that existed at the time.

8.3 Each SCR will be overseen by an SCR Panel, chaired by an independent person (the SCR Panel Chair) and attended by the Overview Author and an officer from the SPB. It is possible that the SCR Panel Chair may be the same person as the Overview Author.

8.4 The role of the SCR Panel is to oversee the review process, and support the review and the work of the SCR Panel Chair and Overview Author.

8.5 Members of the SCR Panel are the 'commissioners' of their agencies' contribution. They should be of sufficient seniority to facilitate communication between the Panel and their

own organisation and make decisions on behalf of their organisation. They should have relevant professional knowledge about the organisations they ask to contribute to the review or secure the involvement of such specialist knowledge. Their role is to:

- Appoint someone to undertake the review in respect of their own agency, this person should have up-to-date relevant professional knowledge about the work they will review. They must not have had prior involvement with the case. This person will usually be required to complete a chronology of the organisation's involvement. They may be required to produce an Independent Management Report (an IMR) or attend a learning event.

- Quality assure the information that their organisation provides to the panel whether by an IMR or other means and ensure it addresses ALL the terms of reference and identifies why actions did or did not take place.

- Ensure that the chief officer of their organisation signs off the IMR before it is sent to the Panel.

- Ensure that information to the panel meets deadlines.

- Ensure that any learning for their organisation that is identified during the review is implemented as soon as possible, and all actions are supported by a clear action plan that can be monitored by the organisation and the SPB.

- Keep their senior managers briefed on any relevant issues as they arise, ensure they are consulted on drafts of the Overview Report and their comments collated and fed back to the Panel and Overview author in accordance with agreed deadlines.

8.6 The SPB Panel will address a number of issues. It will determine the method to be used, the scope of the SCR, e.g. what period of time will be reviewed, who will be included in terms of the family and draw up clear terms of reference. It will consider any parallel processes (e.g. criminal) and ask the SPB Board Manager to secure legal advice from the Law Officers Department (in case this is needed during the review) and identify the need for specialist advice for the Panel. When these issues have been agreed, they will be reported to the Independent Chair for approval.

8.7 The purpose of the SCR is to independently review all the information provided by each agency, in order to establish the following:

- The effectiveness of safeguarding procedures and practice

- The lessons which may be learnt from the circumstances of an individual case
- The way in which local professionals and agencies worked together
- Whether the incident which led to the SCR could have been predicted and/or prevented
- The action which needs to be taken in order to inform and improve local inter-agency practice
- Recommendations for presentation to the SPB

9 Identifying and implementing learning

9.1 The purpose of an SCR is to identify learning, it is important that any learning which emerges during the SCR is implemented as soon as possible. This will then be reflected in the Overview Report.

9.2 There are some important issues to bear in mind:

- The IMRs belong to the agency that produced them, their circulation is at the discretion of their agency Panel member but there is an expectation that they will be shared with the SCR Panel and other IMR authors to aid discussions at the Panel.
- The Overview Report is the property of the SPB and should not be circulated until it has been agreed and published (if it is to be published). The circulation of this report must be closely managed, particularly before it is completed, anonymised, agreed and shared with the family in order to ensure it is not mis-handled.
- *This is even more important when a report is not to be published.*
- This is not to say that the learning cannot be shared with strategy groups and other multi-agency groups during the review , if it is done so carefully and with the agreement of the Independent Chair
- Any report including summaries must be checked against the Quality Markers[4] at appendix 7

9.3 On completion, a learning summary will be completed by the SPB officer for each SCR, whether published or not, these can be safely distributed.

[4] NSPCC and SCIE 2016

Appendix 1 – The Serious Case Review Process

When the Independent Chair has agreed that the case meets the criteria for a Serious Case Review, the following stages will be followed for those SCRs which will include IMRs. If an alternative method of conducting the SCR is agreed the following will need to be amended accordingly.

9.1 **STAGE 1 – NOTIFICATION & INITIATION**

The Chair of the SPB will confirm the decision by sending an initiation/notification letter to the named Chief Officers of all agencies involved, requesting them to:

a) Consider, in consultation with their SPB representative, the agency's involvement with the case and identify a senior manager to be a member of the SCR Panel.

b) Nominate a person (usually at managerial level) to undertake for the agency an Individual Management Report (IMR) or represent their agency at a learning event or other agreed arrangements; this person should have had no operational or management involvement in the case and may be externally commissioned.

The SPB will provide a named Officer to provide support to the SCR Panel. The Chair of the SPB will ensure the contracts for the Independent Panel Chair and Overview Author for the SCR are formally agreed.

The adult/family member(s)/significant other(s) will be informed of the planned SCR by letter from the Chair of the SPB, with the inclusion of accessible additional information explaining the process (Appendix 4).

The initial SCR Panel meeting will agree the scope of the review and the terms of reference which may be amended over time as additional information emerges.

9.2 **STAGE 2 – Chronology or IMR WRITING (Appendix 5)**

Authors will be offered support to consider the Terms of Reference, timeframe for review, chronology process and schedule. An agreed format for the report and guidance will be provided. This will be included in information provided to the authors at the first meeting. A separate author's briefing meeting may be convened, if considered necessary.

The process will start with authors completing a chronology from the records of their agency's involvement during the agreed time period. This, together with the first draft of their IMR if agreed as part of the process, will be submitted to the appointed SPB officer, who will compile a composite chronology and forward documents to the Independent Panel

Chair, Overview Author and SCR Panel members. It is extremely helpful if the chronology includes a summary of the critical events, commentary on the practice of the agency and any issues that need to be addressed from the terms of reference

If an IMR should provide a critique of the agency's actions, in the context of the service at the time, as well as identifying best practice. It should answer all the terms of reference and explain why things did or did not happen and should include recommendations and action plans which indicate how the findings of their IMR and the Overview Report will be disseminated. The SPB named officer can offer support to IMR authors regarding the requirements for the report. IMR reports will include clear version control information. The responsibility for signing off individual agency IMRs at every stage rests with the Chief Officer for each agency.

9.3 **STAGE 3 - FAMILY CONTACT**

Contact with the child/adult/family member(s)/significant other(s) can be difficult and sensitive. The Independent Overview Author will make contact with the family and any relevant others, through the named SPB officer, to offer a meeting with them to explain the purpose and process of the review and seek their views on the services they received. They will also be given assurance that they will be offered a further meeting to receive feedback on the final Overview Report.

The first meeting may also assist in establishing which agencies have been involved with the individual. The terms of reference for the SCR may be amended after this meeting has taken place to reflect the wider perspectives thus identified.

If a Practitioner Learning Event is planned, the meeting with the family should take place beforehand so that what is learned can be shared at the Practitioner Learning event.

The SPB officer will provide the ongoing link to keep those interested parties regularly informed.

9.4 **STAGE 4 - PRACTITIONER EVENTS**

Where it is agreed that events will be set up to include **Front Line Practitioners and Operational Managers directly involved in the case**, attendees will be actively involved in a collaborative and analytical process, with their involvement intended to make a significant contribution to the eventual development of Learning from the case.

Preparation for the Partnership Learning Review (PLR) event with practitioners.

The SCR Panel will need to be clear that they have a full list of appropriate professionals and line managers to invite for the PLR event. This will need to be obtained from the Individual Agency Representatives who compiled the chronologies. The criteria for the professionals to be invited will be that they would have had some form of operational involvement with the child and family. It is particularly important that the most appropriate professionals attend and, for example, it would be unhelpful if practitioners attended but their supervisors/line managers do not. Additionally, requests for other staff to attend who have not had direct involvement with the family should not normally be agreed as this could unhelpfully impact on the dynamics of the group.

The invitation to attend should come from the SCR Panel Chair through the Professional Officer of the SPB. It should give plenty of notice, explain the purpose of the event, the format and process and be given the highest priority. Staff should be pro-actively supported by their line managers in preparing for the event. It may be appropriate for a member of the Panel or the Overview Author to have a pre-meeting with certain practitioners. This could be for a range of reasons but the purpose would be to enable the individual to contribute positively to the multi-agency work at the PLR event and not be hampered by any concerns about a blame culture developing, or that there would an inappropriate focus on individual practice. It is recognised that, in cases of child deaths, some professionals may feel vulnerable, upset or anxious and that a pre-meeting could help to allay those understandable fears and allow them to contribute fully at the PLR event.

If there are likely to be key absences from the PLR event, steps should be taken by the Panel to separately gain their contribution as soon after the PLR event as possible.

The Partnership Learning Review

The PLR event would normally be undertaken over one day, although a more complex case may require an additional half day or day. In summary the purpose of the PLR event is:

- For front line practitioners and operational managers to participate in the inter agency review of this case and in doing so;

- Discuss and agree the factual information compiled about the family in terms of incidents and professional interventions and to gain agreement or additions/changes to these,

- Work alongside the Panel to undertake analysis of the professional practice from the key themes which have emerged in respect of the case

- To identify the key learning themes from the analysis and,

- Identify how the experiences of this case could be used to further develop local inter agency safeguarding practice

The structure of the PLR event must begin with establishing and agreeing the facts of the case. Each participant will have had a copy of the Key Events summary and within the session it will be important to have the Integrated Chronology (colour coded per agency preferably) either displayed around the room or as a resource for reference within the meeting. (However this should be a copy of the chronology without the "comments" section, as this may unhelpfully direct views of participants before they have been able to provide objective input from their direct experiences with the family). It will then be for the participants, in multi-agency groups preferably, to share and discuss the content of the factual information and to add to or question as necessary, the information being presented. It may be that as a result of this exercise some of the factual information will need to be changed, but ultimately there should be a common understanding among the participants of the range and detail of the professional interventions and key events that the family had experienced.

With this knowledge, the group should then be encouraged to consider the "lived experience of the child/adult". This would help participants to view the "story" of what happened with the family from the child/adult's perspective which would help with developing this focus to the later analysis of practice.

The next important part of the PLR event is for the participants to work with the Overview Author and/or Panel Chair to develop the analysis of the case based initially upon the "Key Themes for Analysis", with some specific questions posed to help with addressing these. The meeting will need to give priority to the experience and views of the practitioners and managers present in order to develop consensus views (where possible) about not only what happened, but why interventions or the lack of them occurred in the way that they did. There will need to be a flexible approach to enable professionals to be able to contribute to the key themes for analysis that are most applicable to them. Within this process it will be essential that all actions and decisions, or lack of them by professionals, are viewed within the context of the systems which surrounded them and to what extent they were supportive or otherwise of the work with the family. It will be important that the group is assisted in avoiding hindsight bias in their consideration of what took place with the family, in order to get to some of the detail about how and why certain aspects of professional practice took place in the way they did, It could be useful to identify which factors had an impact and in particular whether they related to: -

- The family dynamics (e.g. difficulty in engaging the family, mobile family)

- Individual/Team practice (e.g. experience, knowledge and direction)

- Organisational/systems issues (e.g. staffing levels, procedural, culture of inter-agency working, organisational change, organisational expectations, management oversight and supervision)

- Community/environmental issues (e.g. local community strengths and weaknesses, local resources or lack of them, impact of racial and ethnic minority issues.),

or probably the most likely,

- A mixture of some or all of the above

The meeting may also find it helpful to identify if there were any "reasonable alternative actions" which could have been undertaken by professional staff at particular stages of intervention, and if so, would they have taken the case in a different direction? The term "reasonable" is important so as to be sure that alternative actions are not only being identified with the benefit of hindsight.

The analysis of the extent that professional interventions were either: -

- Proactive (purposeful to address a problem and to generate change)

- Procedural (undertaken as part of a procedural requirement – e.g. statutory visit as part of a CP Plan, health development assessment)

- Reactive (in response to a request for help, referral, or to a crisis), or

- To what extent they were a mixture of these three types of interventions. This will go some way to understanding the purpose and motivations for interventions which were carried out with the family. Once again these components of practice cannot be viewed without taking into account the wider systems which may have purposefully or inadvertently, directed interventions to take place in a particular way.

The important issue is whether the mode of intervention reflected the needs of the family at the time. Some agencies, such as the Ambulance Service and the Police will tend to only undertake reactive interventions, whereas others are more likely to be a mixture of all three. The ability to successfully intervene with families which present different challenges, such as difficult to engage behaviours, will largely depend on the type of professional intervention and its consistency. The predominant type of intervention may reflect individual style of a practitioner or particular profession, but is just as likely to reflect organisational/team aims or culture and the level of resources available to deliver services.

The final part of the PLR event (or potentially carried over into a second meeting in more complex or detailed cases) will be the development of the Key Lessons Learned. From the analysis of interventions and of how systems were enacted or otherwise in respect of the work with this particular family, this will need to be transposed into areas of learning for

professional practice in the future. It is essential that good practice is fully recognised so as this can be similarly developed for future learning. The outcome from the meeting will therefore be a list of key areas of learning that this case has identified which could make a positive difference in future safeguarding practice.

All the information and outcomes obtained from the PLR event will provide the majority of the material to enable the Independent Author to complete the first draft of the Overview Report.

9.5 **STAGE 5 – SUBMISSION OF REPORTS**

Where IMRs instead of or as well as attendance at practitioner events are requested, they should include action plans, and be circulated to the SCR Panel by the SPB officer in accordance with the agreed time schedule. The IMR author should be aware that they are accountable to their Chief Executive Officer/Commissioning Manager for the quality of the report and action plan. The responsibility for signing off individual agency IMRs at every stage rests with the Chief Officer for each agency.

It is the responsibility of the Panel representative to quality assure the IMR and the action plan and ensure that it is endorsed and includes the signature of the CEO/Commissioning Manager.

The second meeting of the Panel, with Panel Chair, Overview Author and Panel members, will include all authors who will be asked to present their report. IMR authors will consider each IMR against the SCR terms of reference and Quality Markers. A further draft of the report will be requested if an IMR is considered to be:

- Incomplete
- Unclear
- Failing to consider critical information
- Lacking information to evidence decision making
- Requiring further clarification

The Legal advisor may be consulted at this stage about any specific concerns/confidentiality issues.

Agencies will submit an action plan detailing areas identified for development and changes already implemented since the start of the review process. An agreed format will be provided by SPB. Action plans need to include:

- The rationale for the recommendation

- A mechanism that demonstrates how progress can be audited/measured/monitored

- A timescale for completion

Revised IMR reports, including a record of CEO/Commissioning Manager endorsement, will be received by the SPB officer in accordance with the agreed time schedule and forwarded to the Panel Chair and Overview Author. Subsequent Panel meetings do not need IMR authors in attendance; it is the responsibility of their Panel Member to represent the agency.

Administrative responsibilities – IMRs and Overview Reports contain confidential information and care must be taken in their circulation and storage. The following precautions should be taken:

- SCR documents circulated internally (gov.je) may be regarded as secure, but must include PRIVATE & CONFIDENTIAL in the header. Emails to and from external emails should contain documents in password protected format.

- SCR documents should not be included in diary invites, as content would be visible to others with diary permissions.

- Hard copies of documents sent through external and internal post must be clearly marked PRIVATE & CONFIDENTIAL and send recorded delivery.

- SCR documentation must be retained securely. Surplus or draft documents must be shredded.

- Access to IMRs should be restricted to Panel members, their senior managers, Chair and Overview Author; IMR authors do not need to receive copies of IMR reports from all agencies involved.

9.6 **STAGE 6 – OVERVIEW REPORT DRAFTING (APPENDIX 6)**

Once all the information is gathered through the IMRs or learning event, the Overview Author will complete an initial draft of the Overview Report.

The Overview Report highlights relevant learning points and is guided by the terms of reference. It explores how organisations have worked together to comply with safeguarding procedures, identifies lessons to be learnt, policy/procedure/practice challenges to be addressed, relevant research and learning from other SCRs locally or nationally, conclusions and recommendations.

9.7 **STAGE 7 - OVERVIEW REPORT EVALUATION CHECKLIST**

The Overview Report will be submitted to the SCR Panel Chair and Panel Members in accordance with the agreed time schedule and a Panel meeting will review the draft,
check for factual accuracy and;

- highlight areas which require clarification;
- ensure SMART and focused recommendations;
- provide an opinion on publication;
- check against the agreed Terms of Reference;
- check against the SCIE/NSPCC Quality Markers (appendix 7)

Any suggested amendments to the Overview Report will be submitted to the Chair of the SCR Panel within 10 working days of it being distributed. Proposed amendments to the Overview Report will be considered and made at the discretion of the Author of the Overview Report; the content of the report is theirs, it is for the SPB to decide whether to accept the report or not. If a unanimous view cannot be reached it is for the Independent Chair of the SPB to decide.

9.8 **STAGE 8 - PUBLICATION AND DISSEMINATION PROCESS**

Once the Overview Report is completed, it will be submitted to the SCR Sub Group, and then to the SPB for acceptance or rejection by the Independent Chair of the SPB. Lawyers/Data Protection Commissioner will be consulted regarding any legal/data protection issues. This may include consideration of the Overview Report being redacted. .

The SCR sub group will make a recommendation about publication, to the SPB. The principle of public accountability by publishing overview reports in full is contained within the SPB Memorandum of Understanding, as follows:

“Consideration will be given to publishing either in full or in part, the Overview Report of the SCR and the SPB’s response to the review findings. The SPB will give careful consideration when making a decision about publication of the need to balance the benefits of publishing all or some of the review with the need to protect the rights, including privacy rights, of individuals.”

This decision will take into account timings and conclusion of any relevant court and statutory processes. The SPB will take advice as required from relevant parties. The independent Chair of the SPB makes the final decision regarding publication.

The SPB will agree their response to the SCR findings, including any recommendations.

The communications team will support any publication process as agreed by the SPB and facilitated by the SCR sub group. Individual agencies may also wish to prepare and plan for the publication process being mindful of the agreed SPB multi agency communications plan and joint statement.

Any actions requiring immediate change in order to safeguard individuals will be highlighted and relevant agencies informed before the completion of the SCR.
The SPB independent Chair will brief the Assistant Chief Minister/ Policy Group before publication.

The SCR sub group will agree how the relevant information will be shared with family members and other relevant people. Usually the SPB Independent Chair or Overview Author will meet with these interested parties to share a copy of the report and explain the SCR findings/conclusions and inform them of date for publication.

Action plans from relevant agencies must be submitted to the SCR sub group with a requirement that, at a minimum, quarterly updates are sent until all actions are completed.

The SCR SG will agree as to how any lessons learnt will be communicated to staff across agencies and who/how and when individual staff/ practitioners engaged in the SCR process will be de-briefed. In addition, a communication plan to manage information sharing will be established and must include consideration of the impact on schools etc.

The Overview Report in its dissemination/publication format will be distributed, according to the communication plan.

The SCR process will be published on the SPB website.

Anonymised details of the SCR must be included in the independent Chairs Annual Report of the Safeguarding Partnership Boards, including progress on the implementation of the recommendations.

Appendix 2 – SCR Referral Form

Referral to the Independent Chair of the SPBs to consider whether a Serious Case Review should be commissioned in respect of an adult or child.

Before submitting this referral to the Chair of the SPB, please discuss with your agency representative on the SCR SG

The aim of this form is to convey as much information as is available at the time of making the referral. If the information is not available, do not delay in making the referral. Additional facts can be made available later.

(It is recognised that not all details may be available)

Person making referral	Agency			
Contact details of person from whom further information can be sought				Agency file ref number if there is one:
Is this referral in respect of an adult or a child? **If adult, does the adult have capacity?**				Adult / Child Yes / No
Name/s of those who are the subject(s)	✓	D.O.B	Address	Where living

If child, is the child in the care of the SoJ if so under what status?
If child, is the child on the Child Protection Register?
In the case of children: Father
Name:
Address:
Was this adult alleged to be involved in the maltreatment? Yes / suspected / No
Any legal orders restricting parental responsibility/contact

Mother	
Name:	
Address:	
Was this adult alleged to be involved in the maltreatment?	Yes / suspected / No
Any legal orders restricting parental responsibility/contact	

Any adult relevant to the case	
Name:	
Address:	
Was this adult alleged to be involved in the maltreatment?	Yes / suspected / No

Reasons that an SCR should be considered in this case
(Tick any that apply):

In respect of an adult:

a) there is reasonable cause for concern about how the SPB, members of it or other persons with relevant functions worked together to safeguard the adult, ***and***

b)condition 1 or 2 is met.

- *Condition 1 is met if - (a) the adult has died,* ***and*** *(b) the SPB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).*
- *Condition 2 is met if - (a) the adult is still alive,* ***and*** *(b) the SPB knows or suspects that the adult has experienced serious abuse or neglect*

(please indicate which apply)

In respect of a child:

(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.

Cases which meet one of these criteria will **always** trigger an SCR. In addition, even if one of these criteria are not met an SCR **should always** be carried out when a child dies in custody,

in police custody, on remand or following sentencing, in a Young Offender Institution, or a secure children's home, or where a child died by suspected suicide.

Please indicate how the case gives rise to concerns about inter-agency working to protect children and adults from significant harm.

Please very briefly summarise the circumstances of the death/significant harm and the concerns about inter-agency working

Agencies you know to be involved:

Agency **Name of worker if known**

Signed: **Date:**

Organisation/agency:

This pro-forma is a guide to the basic information needed by the SPBs; it is to be used to make a request to the Independent Chair of the SPB for consideration.

Once you have completed section 1 please contact the SPB Board Manager on 01534 444228 and email a copy of the referral form, FAO Professional Officer, to: *safeguardingpartnershipboard@gov.je*

Appendix 3 – Record of Discussion

SCR SUB GROUP RECORD OF DISCUSSION/DECISION. CONSIDERATION OF CASE FOR SERIOUS CASE REVIEW

Initials:	
Date of Referral:	
Date of initial SCR Sub Group:	
Dates of further SCR Sub Group meetings:	

This form consists of the following sections:

Criteria for referring Adult or Children's cases to the (SPB)
SECTION 1 – To be completed by the Serious Case Review Sub Group
SECTION 2 – To be completed by the Chair of the Safeguarding Partnership Board

CRITERIA FOR REFERRING CASES TO THE SAPB

A) *The SAPB will arrange for there to be a review of a case involving an adult in Jersey with needs for care and support (whether or not services have been meeting any of those needs) if—*

(a) *there is reasonable cause for concern about how the SAPB, members of it or other persons with relevant functions worked together to safeguard the adult,*

and

(b) condition 1 or 2 is met.

- *Condition 1 is met if— (a) the adult has died, and (b) the SAPB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).*
- *Condition 2 is met if— (a) the adult is still alive, and (b) the SAPB knows or suspects that the adult has experienced serious abuse or neglect*[5].

[5] Care Act 2014

B) *The SPB will arrange for there to be a review of a case involving a child or young person in Jersey if –*

(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.

Cases which meet one of these criteria will **always** trigger an SCR. In addition, even if one of these criteria are not met an SCR **should always** be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, or a secure children's home, or where a child died by suspected suicide.

SECTION 1 – To be completed with details of the Serious Case Review Sub Group (SG) meeting.			
Date of SG Meeting :		Chair of SG	
Members of SG Present:			
Case Discussion: minutes of SG discussion			

Decision/Recommendation	
Was the SCR SG Meeting quorate?	Yes/No
Was the recommendation unanimous?	Yes/No Comments/reasons for dissent/who?
Were the criteria met?	Please tick all that apply: **ADULT** *There is reasonable cause for concern about how the SAPB, members of it or other persons with relevant functions worked together to safeguard the adult,* ***and*** *(b) condition 1 or 2 is met.* *Condition 1 is met if— (a) the adult has died, and (b) the SAPB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).* *Condition 2 is met if— (a) the adult is still alive, and (b) the SAPB knows or suspects that the adult has experienced serious abuse or neglect*[6]*.* **CHILD** *(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.*
It was agreed that this case	Meets the threshold for a Serious Case Review ☐

	Does not meet the threshold for a Serious Case Review ☐
It was agreed that an alternative form of review should be Undertaken. ☐	Detail of recommendation, reasons and proposed review method to be provided here.
Are there multi-agency issues?	YES ☐ No ☐
Any further action required?	Please detail actions here
Decision fed back to referring agency: Y/N ☐	By whom: By when:

Section 2: To be completed by the Independent Chair of the Safeguarding Partnership Board

My decision is that a Serious Case review 1] should take place for the following reasons   2] should not take place for the following reasons

Name		Dated	
Signed		Organisation	

Appendix 4 – Letter to subject/family

Name
Address 1
Address 2
Parish
Postcode

For Guidance only

safeguardingpartnershipboard@gov.je
Today's date

Dear XXXXX,

Serious Case Review

[May I begin by offering my condolences on the death of your …… I understand this must be an extremely difficult time for your family and I am sorry to intrude on your grief.] I wanted to let you know about a review we are undertaking.

This review is called a Serious Case Review and will consider and evaluate how agencies worked together during their involvement with …… to establish whether there are lessons that need to be learned in order to improve practice. It will try to ensure that agencies like social services, police and other community based organisations understand how this happened and may suggest improvements to their response and the way agencies work together. We would be grateful if you would consider helping the review, which in turn may support professionals to help others. Please do not worry about the details at the moment as you will be given support with this when the time comes. If you would prefer not to participate, that will be fine too.

I have enclosed a leaflet which gives you more information about these reviews and explains that we will contact you in the next few months to ask if you would like to meet the Overview Author …….. to tell him/her your views. …….. is completely independent from all the agencies in Jersey, he/she does not live here and has not worked with any of the agencies that maybe known to you or were known to …….. His/Her role is to look at all the reports that each agency will prepare and bring them together into one Overview Report and make recommendations about how services could be improved.

If you have any questions about the review do please get in touch with [Named SPB officer] on 0153444228 or at the email address above. This review may take around six months to be completed and your contact is welcome at any time. Your comments and insights are very important to help improve services.

Yours sincerely

Independent Chair – Safeguarding Partnership Board

Appendix 5 – Individual Management Reviews

Individual Management Reviews

Introduction

This reference pack provides guidance and support for SCR Panel members and Individual Management Review (IMR) authors who have been commissioned to write an IMR for a Serious Case Review, on behalf of their agency.

1. Criteria for appointing an Individual Management Review (IMR) author

Who should conduct Serious Case Reviews for each individual agency/department?

Each relevant service should undertake a separate IMR of its involvement with the individual, family and/or carers when agreed by the SCR Panel. The format and content of the IMR may be amended over time or for each case reviewed.

a) SCR Panel members must appoint an IMR author a person of sufficient seniority to be able to work at all levels within their agency. The IMR author must be fair in the way that the views of staff are represented. The IMR author should have good knowledge of the service/professional practice being reviewed and be familiar with current safeguarding practice and is expected to produce an independent and objective report within prescribed timescales in accordance with this guidance.
b) The IMR author should have had no direct involvement in the case under review and should not be the direct line manager of their agency representative on the Serious Case Review Panel.
c) The IMR author will prepare the report for their agency, it will be quality assured by the SCR Panel member who will ensure that appropriate senior managers have the opportunity to comment. The Chief Executive Officer and the SCR Panel member should sign it including the action plan, when completed.
d) The author is reminded that their IMR report is critical in ensuring the Overview Writers' understanding of the context of their organisation at the time under review and any organisational issues at the time such as high staff vacancies etc.
e) The IMR author should have unrestricted rights of enquiry and access to staff, records and files. It is envisaged that the IMR author will interview staff that are central to the case.
f) The SCR Panel member must ensure that the relevant staff, in the organisation, are informed of the purpose of the IMR and the process leading to the SCR.
g) The IMR author should identify and indicate the location of all files relating to the individual, family and/or carer and make these files available to the Chair of the Serious Case Review Panel or Overview author, if requested.
h) The compilation of the IMR report will create a significant extra workload. It is important that agencies support their IMR authors. The IMR author should have his/her workload reviewed in order that he/she is allowed sufficient working time to complete the IMR within the strict time scale. The IMR author should receive appropriate clerical support throughout. You will appreciate it may be necessary for the IMR author to be relieved of all their normal duties for the period the IMR report takes to compile.

Copies of staff interview notes should be shared with the interviewee to ensure they are a correct record. Appropriate extracts of the IMR should be shared with staff involved with the case to ensure the report is factually correct prior to submission.

Timescales for the SCR will have been agreed by the SCR Panel. If the IMR report is not received within the prescribed timescale, the work of the SCR panel cannot proceed. This will result in the SPB having to specify to why the report has been delayed further.

Please note, undertaking an IMR is time consuming. It is important that IMR authors leave adequate time in their diaries to complete all the commitments. It might be that due to unforeseen circumstances they are asked at short notice to attend a SCR Panel meeting or provide further information.

When checking whether the author is the right person to be producing an IMR. Please consider the following questions:

1. Is the author a manager or a person in a position of seniority who has not line managed/supervised any of the staff involved in the case?

2. Does the author have the level of experience and professional knowledge to be able to critically analyse the work, systems, policies and procedures of your agency in relation to safeguarding?

3. Is the author sufficiently independent of the staff or services involved in the case?

If the answer is “yes” to these questions, then the criteria are met to be the author for an IMR. If the answer to any of these questions is “no” or if you have any other concerns about your suitability to author an IMR for a Serious Case Review, please speak to your own line manager, or seek advice from the SPPB Professional Officer.

Please contact the SPB Office if further clarification is required.
Tel: **01535 444228**
Email: *safeguardingpartnershipboard@gov.je*

It is compulsory for IMRs from all organisations to include ALL of the headings in **bold** below. If there is no information, or the heading is not applicable, please state this and do not delete any headings.

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INDIVIDUAL MANAGEMENT REVIEW REPORT

Serious Case Review in respect of	Insert Name
Date of Birth	--/--/----
Date of Death or serious incident Delete as appropriate	--/--/----
Author of IMR	Insert Name and Designation of IMR Author here
Agency	Name of agency
Date of submission	Date of first IMR submission to SPB business office.
Version	Version submitted (if applicable)

GUIDANCE: Please ensure that the countersigning person has seen the IMR at each submission stage.

TABLE OF CONTENTS

1. Introduction

Purpose

Professionals and organisations involved in the safeguarding of children and young people or adults at risk need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Each member of the SPB must co-operate and contribute to the carrying out of the review with a view to:
a) Identifying lessons to be learnt from the case
b) Applying those lessons to future cases

Serious Case Reviews and other case reviews should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard;
- 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;
- is transparent about the way data is collected and analysed; and
- Use relevant research and case evidence to inform the findings.

2. About the Author

The statement of Independence should contain the following information:

- Qualifications
- Experience
- Role in the agency
- Independence of the case

It should provide information about the author (name, job title etc) and must provide a clear statement that illustrates their level of independence from the line-management of, and supervision of staff involved in the case.
It should clearly describe the sources of information used to prepare the IMR (e.g. analysis of case records, interviews with staff etc) and when and by whom these were secured.

3. Terms of reference / Scope including time-frame to be covered

Will be provided by the SCR Panel through an initial briefing meeting for IMR authors and should be inserted here.

4. Contextual Information

In considering this aspect of the case, you need to decide whether the context in which the case was conducted impacted on decisions made and if so, such information need only be included in so far as it is relevant to the actions of the organisations concerned.
Most weight should be given to primary information, although secondary[7] and anecdotal information can be considered, but clearly identified as such and given less weight.
The type of information that would be useful is as follows:

- Volume of work
- Staff turnover, sickness and leave cover
- Administrative support
- Organizational change
- Unallocated cases
- The social and community context
- Management and Supervision
- Safeguarding Audit practices
- Risk Management and support policies
- Services and support available to family
- Budgetary constraints and allocation of resources
- Training
- Legal Advice

This is not an exhaustive list and there may be other contextual factors that you would wish to include.

[7] Primary information may be defined as original records of involvement, case recordings and assessments. Secondary information may be information that has been recorded of others views and commentary.

5. Methodology

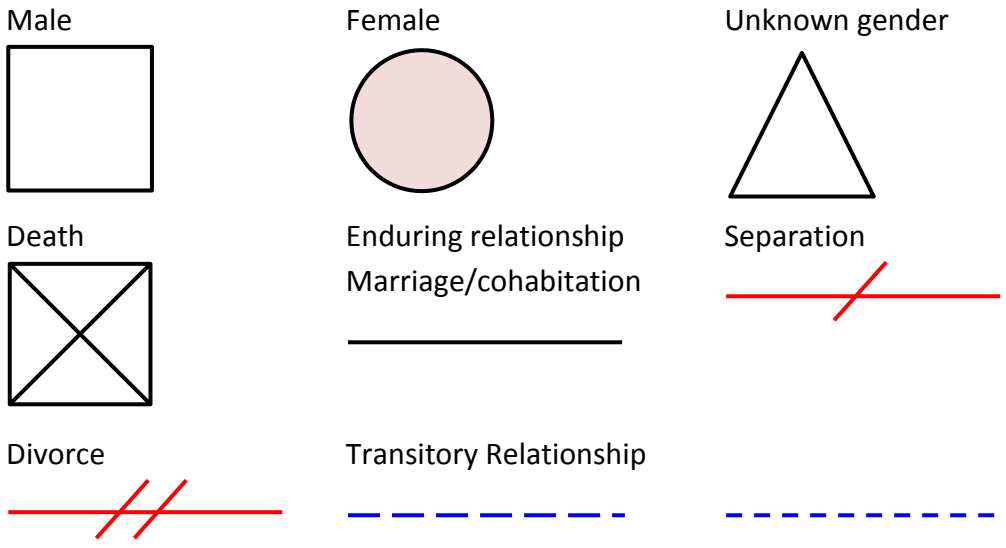
A bullet point list to identify: -

a) How the agency carried out the review.
b) Details of documents seen. (at Appendix B)
c) List of interviews with staff and dates (at Appendix C)
d) Details of information not available/not considered (with reasons).
e) Details of staff involved by initial and job title for the benefit of the SCR Panel only. The overview report will be completely anonymised.
f) Were you given sufficient time to complete the tasks?

6. GENOGRAM/FAMILY TREE

A genogram is a type of family tree which contains additional information about the family composition. It presents key information about the family in diagrammatic form and can include social data such as births and deaths, age and sex of family members and occupation.

Within the genogram there are specific symbols for different items:



The genogram may be used to identify those family members who are aware of the abusive behaviour and those are not. This can be indicated by underlining or drawing a circle round them. It is also useful to use the information from a genogram drawn by family members to compare with a genogram drawn by the individual, family and/or carer themselves. This can reveal differences in understanding and how different family members view their relationships with one another.

Other useful information can also be indicated on the genogram. For example, how family members get on with one another. A dotted line can also be drawn around those individuals who live in the same household as one another.

7. Summary of Facts

Begin your report with a summary of relevant family historic information.
Construct a relevant summarized chronology (in narrative form) on the individual, family and any carers/significant others which could have a bearing on the case and time frame under review. Briefly summarize decisions reached, the services offered and/or provided to the individual /family/carers, and other action taken.
This is not intended to be a repeat of the chronology, but will provide a summary of the information to add a context to the analysis contained within the next section of your report.

8. Analysis of involvement

Consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened but **why** something either did or did not happen. **In addition to the case specific terms of reference provided ensure you consider the following (if not already highlighted)**

- Were practitioners aware of and sensitive to the needs of the individual concerned in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns that the individual may be at risk of abuse and/or neglect?
- When, and in what way, were the individual's/ family member's/carer's wishes and feelings ascertained and taken account of when making decisions about the provision of services? Was this information recorded?
- Did the organisation have in place policies and procedures for safeguarding?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the individual concerned? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?
- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?
- Where relevant, were appropriate safeguarding /case management plans in place, and reviewing processes complied with?
- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the individual [including mental capacity for adults], and were they explored and recorded? This must be referred to.
- Were senior managers or other organisations and professionals involved at points in the case where they should have been?

- Was the work in this case consistent with each organisation's and the SPB's policy and procedures for safeguarding, and with wider professional standards?
- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? 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?
- Was there sufficient management accountability for decision making?

9. What are the learning points from this case?

Are there lessons from this case for the way in which this organisation works to safeguard and protect individuals? Is there good practice to highlight, as well as ways in which practice can be improved?
Are there implications for ways of working; training (single and inter-agency); management and supervision; working in partnership with other organisations; resources? Are there implications for current policy and practice?

10.Recommendations

Recommendations in IMRs should pertain to your agency, as well as to inter-agency practice. These need to include the rationale for the recommendation, a mechanism that demonstrates how progress can be measured /audited, a timescale for completion and a clear identification of the outcomes required :-

a) What changes (if any) could be made to your agency's safeguarding procedures?
b) What changes (if any) could be made in inter-agency working in the light of this case?
c) What action within your agency should be taken in the light of its findings?
d) What areas of good practice are there? Could these be expanded?
e) What action should be taken by whom and by when?
f) What outcomes should these actions bring about?
g) How will your agency review whether they have been achieved and its impact?

Please identify, after each recommendation, the paragraph numbers which contain the analysis leading to the recommendation.

(For Example: Recommendation 1. Amend recording policy to clarify expectations in respect of case discussions with senior managers (see Paras x and x)
What action should be taken by whom and when?

What outcomes should these actions bring, and in what timescales, and how will the organisation evaluate whether they have been achieved?
Are there any immediate statutory requirements for the notification of concerns and are there likely to be any media handling issues?

Signatures required on completed report

Author of IMR and Position	**Chief Officer and Position within Agency**
Date:	**Date:**

SCR procedures v5: http://safeguarding.je/wp-content/uploads/2015/09/SCR-Procedures.pdf

Notes: Please ensure that you use the template given, not a modification. Please details roles not people as people change. Include evidence for example hyperlinked or embedded policies only when the work has been completed. Please do not use acronyms without explanation in the text.

Appendix 5.A – Action Plan

Safeguarding Partnership Board

Safeguarding Partnership Board

(Agency Name) - ACTION PLAN

FOR	
D.O.B	
D.O.D	

Action (including para. of report for reference)	How practice is expected to change	Expected outcome for children or adults	Work already undertaken	Actions still to be carried out	Agency and Role Responsible	Timeframe for completion	RAG – Please write Red/Amber/Green	Evidence and date of completion

APPENDIX 5.B – IMR CEO's Statement.

To be completed and submitted by the agreed submission date for the final version of the IMR.

Name of subject of this Serious Case Review:
Date of Birth:
Date of Incident/Death:
Agency Providing the Report:
Report Author and position:

Evaluation Statement on behalf of agency:

I am satisfied that:

- The IMR takes into account the specific Terms of Reference for this review
- The IMR is:
  - Comprehensive;
  - Well-structured;
  - Objective;
  - Includes good analysis of the information;
  - Provides explanations for any practice which may be of concern –why things did or did not happen;
  - Places emphasis on key findings and lessons
  - Has sound recommendations
  - Has a clear deliverable action plan that includes the outcomes that will be achieved and can be monitored by the SPB

Signed: Date:

…… ……..

Name and Position: …….. ……
(PLEASE PRINT)

Senior Manager responsible for signing off Individual Agency Management Report

APPENDIX 5.C - Records**/**documents reviewed**/**examined including policies and procedures

- Please list them here.

APPENDIX 5.D - Persons seen / interviewed

Name	Dates	Interviewed by

Appendix 6 – The Serious Case Review Overview Report

The Serious Case Review Overview Report should be written in a form that **can be published;** it will include but not be limited to:

- Introduction – Summary of circumstances that led to review being undertaken
- Terms of Reference – including a list of contributors/Review Panel members, job titles of IMR authors and their relevant organisations. Also outline any parallel processes such as criminal proceedings.
- The Facts – including an integrated chronology and summary of relevant information outlined clearly and simply.
- Consideration of any ethnic, cultural or equalities [including capacity, disability] issues and whether they are relevant to the behaviours and approach taken by the organisations and professionals involved
- Analysis – Examination of why and how events occurred, describing decisions made, actions taken or not and examples of good practice. Must be objective and open being clear where systems could be improved.
- The views of the subject/family.
- Improvements that were made as they emerged during the SCR process.
- Conclusion – Summary of the lessons to be learned.
- Recommendations to improve practice
- If necessary, an appendix to highlight any unanswered questions.
- The report should not contain any information that will identify the subject, their family or professionals.

- Quality Markers (QM) Checklist

QM 1	Referral	The case is referred for SCR consideration with an appropriate rationale and in a timely manner
QM 2	Decision making	Sufficient information is gathered on which to base a decision about whether to have a SCR, and to determine the nature of the SCR that is required. The rationale for these decisions is clear, defensible, and reached in a timely fashion.
QM 3	Advising board members	There is transparency among SPB members about the decision making process and outcomes
QM 4	Informing the family	Family member are told what the SCR is for, how it will work, and the parameters and are treated with respect.
QM 5	Clarity of purpose	The Board is clear and transparent from the outset that the purpose of the SCR is organisational learning and improvement, and acknowledges any factors that complicate this goal.

QM 6	Commissioning	The decisions taken about the commissioning of the SCR take into account a range of relevant factors and are made with input from SPB members and in conjunction with the Independent Review Author
QM 7	Governance	The SCR achieves the requirement for independence and ownership of the findings by the Board.
QM 8	SCR management	The SCR is effectively managed. It runs smoothly, is concluded in a timely manner and within budget.
QM 9	Parallel Processes	Where there are parallel processes the SCR is managed to avoid as much as possible duplication of effort, prejudice to criminal trials, unnecessary delay and confusion for staff and families. In particular there must be close collaboration with the Deputy Viscount and the SoJP Viscounts liaison officer in relation to the Inquest process and information provided to it.
QM10	Assembling Information	The SCR gains sufficient information to understand professional practice in the case, its context and relevance today.
QM 11	Practitioner Involvement	The SCR enables practitioners and managers to have a constructive experience of taking part in the review.
QM 12	Family involvement	The SCR is informed by family members and/or significant others knowledge and experiences relevant to the period under review
QM 13	Analysis	The SCR analysis is transparent and rigorous and avoids speculation. It evaluates and explains professional practice in the case to illuminate routine challenges and constraints to practitioner efforts to safeguard children and adults at risk.

QM 14	The report	The report clearly identifies the analysis and findings of the SCR that are key to making improvement, while keeping details of family to a minimum. Findings reflect the explanations for professional practice that the analysis

		has evidenced.
QM 15	Improvement action	The Board enables robust discussion by agencies of what action should be taken in response to the SCR report. This will take place at the SCR sub group. Actions agreed will be deliverable within agreed timescales.
QM 16	Board Written response	The Board agrees a written response ready for publication that explains, clearly and succinctly, what action should be taken in response to the SCR report.
QM 17	Publication	The Board considers the impact of publishing the SCR report and response and decides the best approach to publication or not publishing.
QM 18	Implementation and Evaluation	The SPB integrates the learning from the SCR and its decisions into its business plan and monitors actions to test whether improvements are being made.