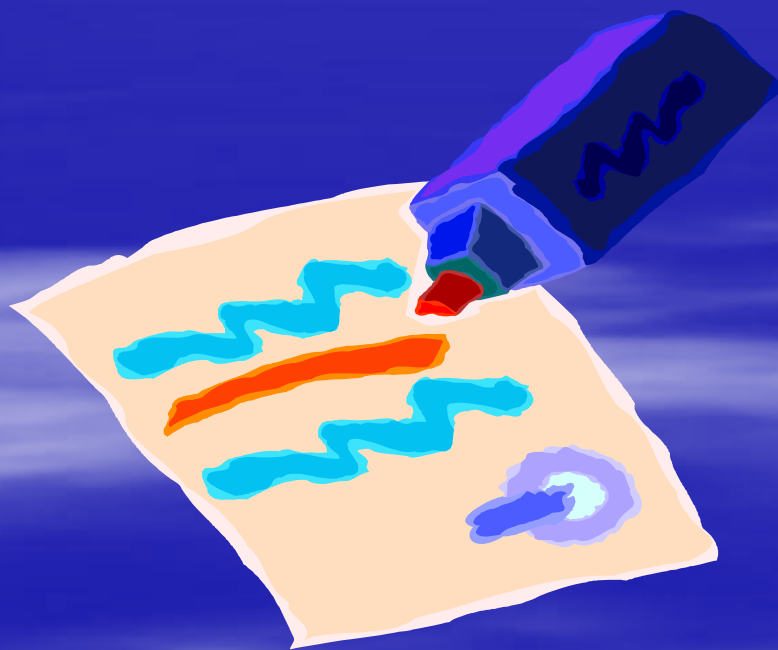
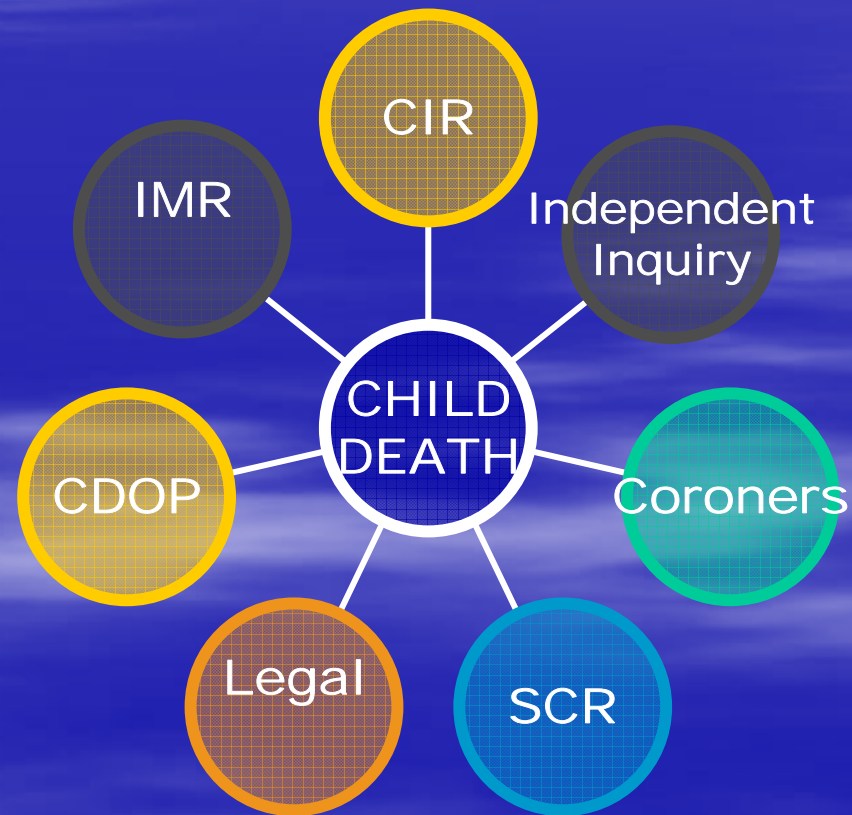


SERIOUS CASE REVIEW Process



**Jane Carwardine
Designated Nurse for
Safeguarding Children.
East Lancashire PCT
April 2008**

Child death review : parallel processes.



What Are Serious Case Reviews (SCRs)?

- They used to be called Part 8 Reviews.
- They are reviews which are undertaken in order to ascertain how organisations have worked together in respect of the case reviewed.

What is the purpose of SCRs?

- **To determine whether or not there are any lessons to be learnt about the way organisations are working together in order to safeguard and promote the welfare of children.**
- **To identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result.**

What is the purpose of SCR's?

AS A CONSEQUENCE OF THIS
PROCESS

INTER-AGENCY WORKING SHOULD
IMPROVE AND MORE EFFECTIVELY
SAFEGUARD AND PROMOTE THE
WELFARE OF CHILDREN.

What are they not?

- They are not inquiries into how a child died or who is culpable- these issues are dealt with by Coroners and criminal courts.
- They are not a mechanism to ascertain which involved professionals should be 'blamed'.

When should an SCR be undertaken?

**The LSCB should undertake a SCR in
EVERY**

**case where a child has died and abuse
or neglect is known or suspected to
be a factor in the death.**

When should an SCR be undertaken?

The LSCB should also consider an SCR if a child

- sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect;
- has been subjected to particularly serious sexual abuse;
- a parent has been murdered and a homicide review is being initiated;
- has been killed by a parent with a mental illness;
- the case gives rise to concerns about inter-agency working to protect children from harm (HM Government,2006).

What are Internal Management Reviews?

These are smaller scale audits of cases which have caused concern but have not fulfilled the criteria for a SCR.

Individual organisations may undertake these as they feel necessary and must share any findings with the SCR Panel of the LSCB.

Request for SCR review

- Agency request to LSCB
- Request from LSCB
- Internal management review vs SCR
- Possible other processes eg mini review, independent review

Debriefing of Staff : Why is it needed?

- **Fear factor – self blame - supportive.**
- **Single/intra agency/multiagency>no agency or discipline bashing.**
- **Internally or externally facilitated**
- **Not part of investigation.**
- **Practitioners (may invite their managers)**
- **Addresses facts, feelings & future. Not investigative.**
- **Positive feedback.**

Timescales for SCRs

- Set by Ofsted usually 3/12
- SCR panel prepared for short timescales
- Performance managed by Ofsted /Govt
NW

Terms of Review

Terms to include

- Records to be viewed ie parental, childs , siblings or other carers.
- Date review should commence from ie the birth of the 1st child.
- Specific information needed ie information relating to substance misuse, parenting capacity, domestic abuse

SCR Process





SCR Intelligence in Lancashire

Acknowledgement to Alison
Moore Lancashire LSCB for her
contribution to this presentation.

Current SCR Business



- At present a total of six serious case reviews are underway
- In addition multi agency activity is being undertaken to two further cases
- Four of the cases relate to children who have died



Current SCR Business

Where did the children live?

| | |
|----------------------------------|-------------|
| Lancashire East | Five |
| Lancaster, Fylde and Wyre | Two |
| South Lancashire | One |

How old were the children?

2 children were over the age of 10 years

6 children were under the age of 10 years



Features

- **Violence in the household**
- **Adult Substance Misuse (predominantly alcohol)**
- **Adult Mental Health Issues**
- **Families well known to statutory agencies**



Emerging Issues

- **Poor record keeping**
- **Lack of co-ordinated information sharing meetings**
- **Lack of Communication between agencies at the right time, about the right issues**
- **Thresholds**
- **Referrals not being made at the right time**
- **Focus on the needs of the adult rather than the needs of the child**



National Perspective

On 31 January 2008 DCSF published two reports relating to Serious Case Review Activity:-

<http://www.everychildmatters.gov.uk/socialcare/safeguarding/seriouscasereviews/>

- Improving Safeguarding Practice – Study of Serious Case Reviews (2001-2003)
- Analysing Child Deaths and Serious Injury through Abuse and Neglect – What Can we Learn? A Biennial analysis of Serious Case Reviews 2003-2005

National Research

Key Findings and Learning Points

- Two thirds of the 161 children died and a third were seriously injured.
- 47% of the children were aged under one, but 25% were over 11 years, including 9% who were over 16. Many older children were '*hard to help*' and failed by agencies.
- 12% of children were named on the child protection register, and 55% of children were known to children's social care at the time of the incident.
- The families of very young children who were physically assaulted (including those with head injuries) tended to be in contact with universal services or adult services rather than children's social care.
- In families where children suffered long term neglect, children's social care often failed to take account of past history and adopted the '*start again syndrome*'.
- In the cases where the information was available, well over half of the had been living with domestic violence, or parental mental ill health, or parental substance misuse.

Additional background reading

- Working Together to Safeguard Children (HM Government 2006) : chapter 8 pp 168-180.
- Learning the Lessons from the Past- a review of serious case reviews (DOH 2002)
- Lancs LSCB guidance- Protocol for case reviews and critical incidents:
- Lancs LSCB guidance-relating to health's responsibility within serious case reviews and critical incidents
- Reder, P. & Duncan, S. (1999). Lost Innocents- a follow up study of fatal child abuse. Routledge.
- Parton,N. (2004). From Maria Colwell to Victoria Climbié: Reflections on Public Inquiries into Child Abuse a Generation Apart. Child Abuse Review Vol13 pp80-94.