Serious Case Review Quality Markers

Supporting dialogue about the principles of good practice and how to achieve them

scie social care institute for excellence

NSPCC

First published in Great Britain in March 2016
by the Social Care Institute for Excellence and NSPCC

Written by Sheila Fish, and Fiona Johnson

This document is available online
www.scie.org.uk/lipp or www.nspcc.org.uk/lipp

Social Care Institute for Excellence
Kinnaird House,1 Pall Mall East,
London SW1Y 5BP
Tel 020 7766 7400
www.scie.org.uk

NSPCC
Weston House, 42 Curtain Road
London EC2A 3NH
Tel 020 7825 2500
www.nspcc.org.uk

Contents

Acknowledgements

The SCR Quality Markers were produced as part of the Learning into Practice Project, a one-year DfE-funded project conducted by NSPCC and SCIE between April 2015 and March 2016. For more information see nspcc.org.uk/lipp or scie.org.uk/lipp

The SCR Quality Markers have been developed in close collaboration with a development team made up of experienced independent reviewers:

Edi Carmi
James Blewett
Jane Wonnacott
Keith Ibbetson
Nicki Pettitt
The LiPP project team for this work stream included:
Natasha Andrews, SCIE
Kevin Ball, NSPCC

It was led by:

Sheila Fish, SCIE
Fiona Johnson, Independent Consultant

The National Association of Independent LSCB Chairs contributed via

Alex Walters
David Ashcroft

We are grateful to the five LSCBs whose reviews we used to test the quality markers in the development process.

About this document

This document contains 18 Quality Markers for case reviews and Serious Case Reviews (SCRs). Covering the whole process, the quality markers provide a consistent and robust approach to SCRs. They are based predominantly on established principles of effective reviews / investigation as well as SCR practice experience and expertise.

1. Referral
2. Decision making
3. Advising board members
4. Informing the family
5. Clarity of purpose

Setting up the review

6. Commissioning
7. Governance
8. SCR management
9. Parallel processes
10. Assembling information
11. Practitioner involvement
12. Family involvement
13. Analysis

Running the review

14. The report
15. Improvement action
16. Board written response
17. Publication
18. Implementation and evaluation

Outputs and outcomes from the review

How they help

The SCR Quality Markers are intended to support commissioners and lead reviewers to commission and conduct high quality reviews. They capture principles of good practice and pose questions to help commissioners and reviewers consider how they might best achieve them. SCRs are a complex field of activity where simple rules rarely apply, so judgement is often needed. The Quality Markers are therefore designed to stimulate discussion and support informed judgements. They are not a ‘how to’ handbook because there are a variety of ways in which they can be achieved. The quality markers do not presume or promote any particular model or approach for how to achieve them. They support variety, innovation and proportionality in approaches to case reviews.

How they have been developed

The SCR Quality Markers have been produced by a development group made up of eight experienced lead reviewers. They are based on research evidence, practice experience and statutory requirements.

As part of the Quality Markers development process, feedback was provided by 57 LSCB Chairs, Board managers and lead reviewers at two summits. In addition the markers were tested against five SCRs, supplemented by input provided by the Association of Independent LSCB Chairs.

How the Quality Markers are presented

Each Quality Marker is presented using the following structure:

- **Quality statement** – a summary description of the Quality Marker
- **Rationale** – further explanation of the marker and why it is important and necessary
- **How might you know if you are meeting this QM?** – questions to consider for self-assessment
- **Knowledge base** – any research or practice evidence underpinning to the marker
- **Equality & diversity** – any specific equality and diversity issues that are important to consider
- **Link to statutory guidance & inspection criteria** – any relevant regulations, statutory guidance and national minimum standards
- **Tackling some common obstacles** – These have been identified by the Lead Reviewers and LSCBs during the LIPP project and can be added to over time.

How they can be used

The SCR Quality Markers can be used in a number of different ways and at different times during a single SCR.

When	Which Quality Markers	For what purpose
At the beginning	all	To create clarity and transparency of what is being commissioned
At the beginning	all	To support practical planning and preparation
Progressively over the course of the review	individual markers as appropriate	To manage and quality assure the process
At the end	all	To structure reflection retrospectively on the review and identify improvements for future SCRs

The markers should not be treated as a process map because while the three clusters in which they are structured are broadly sequential, the components within them are not.

Serious Case Review Quality Markers

Overview

Setting up the review

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 LSCB members about the decision making process and outcome.
QM 4	**Informing the family**	Family members 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.

Running the review

QM 6	**Commissioning**	The decisions about the commissioning of the SCR take into account a range of relevant factors and are made with input from LSCB members and in conjunction with the lead reviewer(s).
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.
QM 10	**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' knowledge and experiences relevant to the period under review
QM 13	**Analysis**	The SCR analysis is transparent and rigorous. It evaluates and explains professional practice in the case to illuminate routine challenges and constraints to practitioner efforts to safeguard children

Outputs and outcomes from the review

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 the 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.
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 how best this can be achieved.
QM 18	**Implementation and evaluation**	The LSCB integrates the learning from the SCR and its decisions about how it is going to respond into its business plan and monitors actions to test whether improvements in services are being made.

Serious Case Review Quality Markers
Supporting dialogue about the principles of good practice
Quality Marker 1: Referral

Quality statement: the case is referred for Serious Case Review (SCR) consideration with an appropriate rationale and in a timely manner

Rationale

Individual cases need to be referred to the Local Safeguarding Children Board (LSCB) if they are to become multi-agency learning opportunities. The statutory guidance allows two sets of circumstances in which a case should be referred for SCR consideration. First, cases where an SCR is required because the case meets the statutory criteria. Second, LSCBs can also select to commission an SCR on cases that do not meet the statutory criteria, but where an SCR is thought likely to produce useful learning for other reasons. This can be linked to local learning priorities. The local learning and improvement framework and the LSCB business plan should set out the priorities for learning in the local area. Given the range of reasons that a case can be referred for SCR consideration, it is important that the rationale is clearly laid out in the referral.

There are many reasons why a rapid referral of serious incidents and tragic outcomes is often beneficial. The more current the practice being reviewed, the more directly applicable the learning, and practitioners are more likely to be available to be involved if the SCR takes place without delay. It also allows any urgent risks to be highlighted and enables any patterns to be seen (e.g. common victims or perpetrators or institutions) and, as in all forms of accident investigation, it is important to address immediate problems that have an unambiguous practical solution. However, the complexity of modern systems and arrangements often defies immediate practical remedy and needs first to be carefully researched.

Other cases legitimately may be identified and referred later, but still be timely.

How might you know if you are meeting this quality marker?

1. Is the rationale for the referral clear, and supported by adequate information?
2. Does the referral state explicitly whether the case met the statutory criteria, or if it was referred for another reason?
3. Are there explanations for any delays in the referral?

Knowledge base

- We have not been able to identify any relevant research base or practice knowledge for this quality statement.

Link to statutory guidance and inspection criteria

- 'Working together' (HM Government 2015) provides the statutory framework – relevant sections are: p 72, Regulation 5(1)(e) and (2) of the LSCBs 'Regulations 2006' which set out the requirement for LSCBs to undertake reviews of serious cases in specified circumstances; and pp 73–74, which provides guidance regarding timescales for reviews.

Tackling some common obstacles

- Where LSCBs have previously gained useful learning from SCRs they are more likely to refer cases for potential review.
- Where the local learning and improvement framework and priorities are well publicised, agencies will be more inclined to think about referring cases for reasons other than the statutory criteria.
- The clearer and more widely understood are the LSCB expectations regarding the various reasons a case could or should be referred for SCR, the greater the likelihood that appropriate cases will actually be referred, and in a clear and timely manner.

Serious Case Review Quality Markers
Supporting dialogue about the principles of good practice
Quality Marker 2: Decision-making

Quality statement: the decision about whether to have a Serious Case Review (SCR), and the nature of the SCR that is required, take into account factors related to the case and the local context. The rationale for these decisions is clear, defensible and reached in a timely fashion.

Rationale

Following the referral of a case for SCR consideration, there are two purposes for information-gathering. The first is to determine whether the case meets the statutory criteria and if it does not, whether the Local Safeguarding Children Board (LSCB) still wants to commission an SCR. The second is to make an initial determination of the nature of the SCR to be commissioned.

When doing the initial thinking about the size and scope of the SCR, the LSCB chair has to weigh up a wide range of issues including:

- what useful learning it will enable
- how it relates to previous learning
- resource constraints
- impact on practitioners
- impact on the family
- other reviews/investigations being conducted at the same time
- political and media interest
- public trust in safeguarding organisations

Therefore it is necessary to gather sufficient and varied information to weigh up these issues.

The reasons for the chair's decisions need to be explicit and justifiable to member agencies, central government, professionals involved and family members. Drift in decision-making will delay the review and learning being achieved. Decisions on the nature and scope of the review may need to be revisited during the commissioning of independent reviewers and as new information comes to light.

How might you know if you are meeting this quality marker?

1. Is sufficient information gathered, both about agency contact with the child or young person and a range of contextual information, to inform the decision-making?
2. Are key agencies being asked to provide at least minimum data about their involvement with the incident and/or family?
3. Are checks with neighbouring LSCBs being planned if it is apparent that the family has lived outside the LSCB area?
4. Are there adequate mechanisms to support an informed inter-agency discussion to achieve a recommendation being made to the chair on whether an SCR should be conducted?
5. Is any delay justified by the circumstances of the case?
6. Is there consideration of independent challenge to the decision-making such as peer discussion with another LSCB chair?
7. Is the decision informed by the statutory criteria and was this evidenced in the record of the decision made by the chair?
8. Is the decision about the nature of the SCR informed by local learning and improvement activity, and outstanding needs?
9. Do LSCB member agencies have the opportunity to provide input to the chair's decision?

Knowledge base

- Practice experience of conducting SCRs suggests the seriousness of the outcome of the case should not dictate the size of the SCR. LSCBs may already know the causes of practice problems evident in a new case, from previous SCRs. However, LSCB chairs often have to consider wider public interest issues in this decision (see QM5).
- There is a suggestion from the experience in the health field of reviews, that there are benefits from doing fewer reviews of a high quality, rather than many which are less detailed. See for example the rationale for establishing a national investigation branch for NHS patient safety incidents.

Link to statutory guidance and inspection criteria:

- 'Working Together' (HM Government 2015) sets out an LSCB's function in relation to SCRs in Chapter 4, paragraphs 18–20, p 75.
- The National Panel routinely cross-references notifications of incidents with decisions about SCRs and reported concerns about delays in decision-making in the second annual report.
- The Office for Standards in Education (Ofsted) is requiring boards to demonstrate that there have been decisions in relation to notified incidents.

Tackling some common obstacles

- Where LSCBs have sufficient funds they are more likely to explore broader learning opportunities rather than focusing exclusively on statutory SCR criteria.
- Where the LSCB business unit has sufficient independence from member agencies this facilitates information-gathering and dispassionate decision-making.

Serious Case Review Quality Markers

Supporting dialogue about the principles of good practice

Quality Marker 3: Advising board members

Quality statement: there is transparency among Local Safeguarding Children Board (LSCB) members about Serious Case Review (SCR) decision-making and outcome

Rationale

Successful learning and improvement is achieved through maximum agency input to support the SCR, including the resource commitment that is required. This is more likely to be achieved if the decision-making and outcome is known by all LSCB members.

The chair has specific delegated authority for decision-making about SCRs and LSCB member agencies need to have confidence in the discharge of that function, which should be transparent.

For the issue of informing any other parties that may have an interest, see QM9 (parallel processes).

How might you know if you are meeting this quality marker?

1. Is there a mechanism to advise the LSCB membership as a whole of the decision about whether to proceed with the SCR and outcome of this process?
2. Is the rationale for the decision of the chair to hold an SCR (or not) full and explicit in its communication with LSBC members?

Knowledge base

- We have not been able to identify any relevant research base or practice knowledge for this quality statement.

Link to statutory guidance and inspection criteria

- We have not been able to identify any relevant statutory guidance or inspection criteria statement, however ‘Working together’ (HM Government 2015) requires the LSCB to have a learning and improvement framework and states that ‘These processes should be transparent …’ (p 72).

Tackling some common obstacles

- There is not an established tradition in LSCBs of transparency in relation to SCR decision-making.
- Strong communication systems between working groups, such as the SCR sub-committee or equivalent, and the wider Board assists all LSCB members to understand the decision.

Serious Case Review Quality Markers

Supporting dialogue about the principles of good practice

Quality Marker 4: Informing the family

Quality statement: family members are told what the Serious Case Review (SCR) is for, how it will work, and the parameters, and are treated with respect

Rationale

A core principle of safeguarding is to work with families in an open and honest way and this needs to be replicated in the SCR. Being clear about the purpose and function of the SCR helps to manage the expectations of family members about what the SCR can achieve and what it will not cover. Within this context family are usually close relatives, including those with parental responsibility.

How might you know if you are meeting this quality marker?

1. Is there a reliable mechanism to enable the Local Safeguarding Children Board (LSCB) to inform family members of the SCR at the earliest stage possible?
2. Is the standard correspondence that is used for family members about the purpose, process and parameters of the SCR adequately clear, accessible and kind?
3. Are the opportunities being offered to family members to discuss any queries or clarifications flexible, and do they give them a realistic chance of doing so?
4. Is there overt support for legitimate questions posed by family members being addressed honestly?

Knowledge base

Recent research into family involvement in SCRs identified four reasons for such involvement:

- human rights
- a child-centred perspective
- a primary source of knowledge and information
- altruistic and cathartic motives (Morris et al., 2013).

Equality and diversity

- The needs of families where English is not a first language can require specific interventions such as interpreting and translation.
- Letter writing may not be an adequate form of communication with families where there is fear and/or conflict with authorities. Consideration of alternative means of making contact is required in such cases.
- Disabled parents can require additional support.
- Consideration of the particular needs of children (siblings) can be required.
- Involving adolescents can require consideration of the use of a range of methods for communication including email/text/Skype/Facebook.

Link to statutory guidance and inspection criteria

- 'Working together' states: 'families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively' (HM Government, 2015: 74). It does not specify the need to inform families but inviting them to contribute assumes they have been informed.

Tackling some common obstacles

- Establishing a routine process of informing families at the same time that the LSCB is informed increases the chance that this does not get delayed or overlooked.

Serious Case Review Quality Markers

Supporting dialogue about the principles of good practice

Quality Marker 5: Clarity of purpose

Quality statement: the Local Safeguarding Children Board (LSCB) is clear and transparent, from the outset, that the purpose of the Serious Case Review (SCR) is organisational learning and improvement, and acknowledges any factors that complicate this goal

Rationale

SCRs often provoke fear, for individuals and agencies, that the process involves looking for someone to blame for the incident or outcome of the case. In contrast, the purpose of SCRs should be organisational learning and improvement and, where relevant, the prevention of the reoccurrence of similar incidents. This framework accepts that errors are inevitable and, where they are identified, they become the starting point of an investigation. Individual and organisational accountability is manifest through being open and transparent about any problems identified in the way the case was handled, and demonstrating a commitment to seek to address the causes. In many SCRs this is what the LSCB wants the SCR to achieve. It is as simple as that. Communicating with clarity the learning and improvement purpose helps address fears and uncertainties over the function of the SCR. It also helps reduce defensiveness on the part of those affected.

In some cases, the situation is not as straightforward. Certain cases and/or local circumstances can trigger government and/or media expectations about individual(s) and/or agencies being held to account by disciplinary means. The need to identify someone to blame can also become a driving factor for senior managers. Alternatively, there is often an expectation that any practice identified through the SCR as falling below expected standards is reported to the agency concerned, so they can consider the need for disciplinary or capability processes. These different agendas can create significant challenges to the learning and improvement goal of the SCR. On the one hand, they can create false expectations that the SCR itself will ascribe individual or corporate blame. On the other hand, such circumstances can muddy the waters about the purpose of the SCR because while the SCR is not designed to apportion blame, it can provide information that feeds into individual or corporate discipline processes, or clarify the grounds for needing to initiate them. As a result, claims that the purpose of the SCR is learning can ring hollow for those involved. An honest articulation of any tensions and contradictions that exist in relation to the goal of learning in an SCR is therefore recommended.

How might you know if you are meeting this quality marker?

1. Has there been communication with all the necessary parties about the purpose of the review (e.g. LSCB members, involved agency leaders and practitioners directly involved as well as those conducting the review)?
2. Has this communication been articulated in a strong and positive fashion, underlining the learning and improvement purpose of the SCR?
3. Have any complicating circumstances been honestly acknowledged?

Knowledge base

- There is a large body of safety management literature that addresses the same problems as child protection of understanding how poor outcomes arise and how they can be reduced. A key lesson is that practitioner errors generally arise from the interaction of several areas of weakness in the system, not from one major mistake by an individual. Investigations are therefore seen to need to explore how the system functions more generally and routinely. They seek to identify what supports good practice and what is making poor standards of performance more likely. See also 'An organisation with a memory' (The Chief Medical Officer, 2000), ACPO risk assessment principles as quoted in 'The Munro review of child protection: interim report - the child's journey' (Munro, 2011p 96), and the Munro Review of Child Protection reports themselves.
- Professor Don Berwick, in the report of his review into patient safety in the NHS (2013) stresses the need to differentiate carefully between error and neglect or wilful misconduct: 'Because human error is normal and, by definition, is unintended, well-intentioned people who make errors or are involved in systems that have failed around them need to be supported, not punished, so they will report their mistakes and the system defects they observe, such that all can learn from them. On the other hand, harm caused by neglect or wilful misconduct does warrant sanctions in health care, just as it does in other settings' (p 12). NHS England recommends ascribing culpability only for reckless or malicious actions by individuals – see the NHS Incident Decision Tree (The Health Foundation 2013).
- Research about accident investigation supports developing a just culture for SCRs that accepts accountability (organisational and individual) but does not apportion blame (Dekker 2012).

Link to statutory guidance and inspection criteria

- 'Working Together' (HM Government 2015) defines the purpose of SCRs as 'organisational learning and improvement, and the prevention of reoccurrence'. There is a requirement for 'transparency about the issues arising from individual cases and the actions which organisations are taking in response to them' (p 72).

Tackling some common obstacles

- Strong, overt leadership about the purpose of the SCR being to understand 'what happened and why' and to make recommendations which will lead to the improvement of services, helps address tensions and uncertainties over the function of SCRs and minimise defensiveness on the part of everyone affected by the SCR.
- Adopting and promoting an agreed model of organisational accident causation can help clarify what a focus on learning means, and provide a range of new terms to explain it.
- The establishment of a 'just culture' ahead of time will help senior managers and board members deal with tensions and contradictions about 'accountability' with honesty and integrity. The principles of a 'just culture' can be established as foundations to the local learning and improvement framework, and applied to all review, audit and evaluation work.
- Establishing a 'just culture' will make it less likely that senior managers and board members will be unduly influenced by inappropriate attention from government, regulatory bodies and other external influences such as the media expectations about individual(s) and/or agencies being blamed and punished through the SCR.

Serious Case Review Quality Markers
Supporting dialogue about the principles of good practice
Quality Marker 6: Commissioning

Quality statement: the decisions about the precise form and focus of the Serious Case Review (SCR) to be commissioned take into account factors related to the case and the local context. They are made with input from Local Safeguarding Children Board (LSCB) members and in conjunction with the lead reviewer(s)

Rationale

An SCR needs to produce learning in a proportionate manner. An individual review also needs to help nurture cultures and partnerships that are capable of learning and improving. Initiating the substantive work of the review therefore requires that further detail is added to initial decisions made about the kind of SCR to be undertaken. This includes specifying:

- the breadth and depth of the investigation
- any specific areas of focus or questions
- the method or approach to be used to assemble the relevant information and deliver the required analysis
- the knowledge and skills needed from the reviewer(s) to lead the process
- the agencies that need to be involved.

The specifics of the case itself are a key factor in making these decisions, including:

- types of strengths and vulnerabilities of the family and carers, kinds of risks posed to the child(ren) or young person
- the gravity and/or complexity of apparent concerns about professional practice in the case
- any specific legal requirements (such as the Human Rights Act when a child or young person who was in state care has died).

Other relevant factors that need to be taken into account are contextual, including:

- previous local learning and areas or issues about which less is currently known
- availability of reviewers and their knowledge, skills and competence
- public interest
- local capacity relative to other ongoing learning and improvement activity
- strategic learning and improvement plans and priorities
- the capacity of the LSCB to carry out and learn from the review at that particular time and any factors currently affecting that capacity

- features of the local context that impact on the capacity of practitioners to be openly involved at this time.

These factors are not discrete but interact with and influence each other, which means that making decisions about what is a proportionate approach is complicated and requires judgement. Involving LSCB members and working with the lead reviewer(s) to decide how best to accommodate this range of factors will enable the relevant information to be assessed and the right expertise to be brought to bear.

How might you know if you are meeting this quality marker?

1. Are LSCB members given the opportunity to input any information they think relevant to agreeing a proportionate approach for the review?
2. Are the lead reviewers able to properly influence the scope, nature and approach of the SCR?
3. Have the full range of factors related to both the case and context that are detailed in the rationale of the quality marker (QM) been considered in decision-making about what exactly is being commissioned?
4. Does the scoping document or terms of reference for the SCR explain the rationale for decisions about proportionality that have been reached by referring to factors related both to the case and context?

Knowledge base

- Practice experience highlights how powerfully contextual factors influence what can be achieved in an individual review.

Link to statutory guidance and inspection criteria

- 'Working Together', p 73 para 10 states that 'the approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined'.
- It also provides detail about the requirements of lead reviewers (HM Government 2015: 78).
- The National Panel has repeatedly stressed that a proportionate approach needs to be adopted to enable the aims of the SCR process to be met in a way that is flexible and relevant to the individual case circumstances, without incurring excessive cost or workload. See for example, 'First report' para 20.

Tackling some common obstacles

- Strong leadership by the LSCB chair about the full range of factors that need to be taken into account helps avoid some being disproportionately prioritised more than others.
- Up-to-date knowledge about the availability of suitable lead reviewers will make their identification easier.
- Having someone within the LSCB team with specific responsibility for SCRs in the context of the learning and improvement framework makes this easier.
- A detailed understanding of what constitutes an effective investigation by relevant LSCB personnel will support the discussions and decision-making.
- Some of the factors relevant to deciding what proportionate looks like in a particular review are local factors, but some emanate from outside the area, and many are beyond an LSCB's power to control. In this context transparent decision-making that has taken account of the above factors can help anticipate challenges for the review and can help focus and manage expectations.
- Cases that cross single or multiple borders add considerable complexity to commissioning considerations and need to be discussed early on. Involving all relevant LSCBs helps foster collective ownership of decision-making. Consideration of a cross-LSCB governance body can be useful.

Serious Case Review Quality Markers
Supporting dialogue about the principles of good practice
Quality Marker 7: Governance

Quality statement: The Serious Case Review (SCR) achieves the requirement for independence and ownership of the findings by the Local Safeguarding Children Board (LSCB)

Rationale

Rigorous SCR analysis requires a significant degree of objectivity combined with sufficient understanding of context and organisational arrangements. Subsequently, changing practice is the responsibility of the LSCB and member agencies and they are more likely to be able to achieve this if fully engaged in and supportive of the findings of the SCR. Both these issues create a necessary tension between the independence of lead reviewer(s), on the one hand, and local involvement and ownership of the findings and/or recommendations by LSCB members on the other. Governance arrangements need to manage this tension to best effect.

How might you know if you are meeting this quality marker?

1. At the start of the review, is there clarity about roles and responsibilities and are there explicitly stated governance arrangements (e.g. are the terms of reference/scoping document clear about who is responsible for what – who conducts the review, who provides quality assurance and challenge and who is ultimately accountable)?
2. Is the system for quality assurance of the process and sign-off of the report set out clearly from the start?
3. What are the mechanisms to allow challenge to the information and analysis of the review, so that the findings/recommendations have been thoroughly considered before the report is finalised and taken to the LSCB?
4. Do the quality assurance mechanisms manage the tension between the independence of the lead reviewer(s) and the ownership of the final report by the LSCB in a fair and balanced fashion?
5. Is there clarity about what happens when agreement cannot be reached about the analysis and findings/recommendations, and how impasses are handled?

Knowledge base

- Practice experience of lead reviewers indicates that if governance arrangements are not explicitly stated at the beginning of the SCR there can be complications when the SCR report is to be completed.

Link to statutory guidance and inspection criteria

'Working together' (HM Government, 2015: 78) identifies the need for the independence of the lead reviewer and states that 'The LSCB Chair should be confident that such a review will thoroughly, independently and openly investigate the issues' (para 20, p 76).

Tackling some common obstacles

- Clarity about roles and responsibilities can assist in resolving any tensions between independence and ownership.
- Care needs to be taken that scrutiny and challenge are not personalised and do not become inappropriate pressure.
- Processes of editorial support or peer review need to be explicit and a part of the formal process, given the sensitive interplay with the meaning being conveyed. This input is best provided at the analysis stage rather than later.
- Where compromise cannot be reached between the lead reviewer and the LSCB members it is best for this to be acknowledged and addressed in the final report that is presented to the LSCB.
- Where the analysis is jointly produced by a local group of senior managers and the lead reviewer(s), this can help reduce pressure to make inappropriate amendments. However, increased collaboration also creates challenges for lead reviewer(s) about how they exert and maintain their independence.
- Keeping senior managers up to date so that there are no surprises about findings at the end of the review helps cultivate ownership of those findings.

Serious Case Review Quality Markers

Supporting dialogue about the principles of good practice

Quality Marker 8: SCR management

Quality statement: the Serious Case Review (SCR) is effectively managed. It runs smoothly, is concluded in a timely manner and within budget

Rationale

Undertaking an SCR is complex and requires rigorous management skills, good organisation and coordination to avoid wasting time and money.

How might you know if you are meeting this quality marker?

1. Is there a clear plan with allocated roles and responsibilities for the transmission of information?
2. Is sufficient administrative support provided to the SCR?
3. Is the SCR progressing smoothly and in line with anticipated timeframes?
4. Are mechanisms in place to inform the LSCB of any delays and reasons for them?
5. Are any matters arising that could have been reasonably anticipated and addressed prior to the review starting?
6. Is there enough slack in the plan to allow for legitimate delays?
7. Does the lead reviewer have sufficient capacity to do the review to a high standard?

Knowledge base

- Practice knowledge from experienced lead reviewers indicates that good organisational skills are key to effective SCRs.
- The Office for Standards in Education (Ofsted) summary evaluation reports evidenced previously the impact of not having effective management of the SCR on timescales etc. (Ofsted, 2008 2009, 2010).

Link to statutory guidance and inspection criteria

- Apart from suggested timeframes for completion, there are no statutory requirements for the management of SCRs.

Tackling some common obstacles

- Good management of the SCR is facilitated by there being dedicated administrative and management time.
- Active leadership by the LSCB chair often assists in successfully addressing challenges that arise during the SCR.
- Where there are changes in key personnel in the LSCB, formalising a review helps identify the impact on the SCR, as the changes can lead to confusion if not addressed.

Serious Case Review Quality Markers

Supporting dialogue about the principles of good practice

Quality Marker 9: Parallel processes

Quality statement: 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

Rationale

SCRs are often conducted in parallel with criminal, civil or regulatory investigations and human resources (HR) procedures. Other reviews may also be conducted at the same time, such as domestic homicide reviews, mental health independent investigations (ref below) and safeguarding adult reviews. There may be complaints or civil litigation. When a child has died there will be a coroner's Inquest. There may be proceedings in the family court in relation to surviving children.

These reviews and investigations have distinct purposes and some are the subject of separate statutory guidance. This means they are not all mutually compatible. No process is inherently more important nor therefore automatically takes precedence, however judges in civil and criminal proceedings may make orders that impact on the SCR.

So when they overlap and interact it can cause difficulties and tensions. There are some protocols agreed between key agencies (see below), however they commonly leave much to the discretion of involved individuals. The interactions therefore need to be managed carefully and take into account the importance of:

- SCRs being completed without unnecessary delay
- not interfering unnecessarily in other investigations or prejudicing their outcome
- minimising duplication of effort and expense
- involved professionals and families understanding the role of different reviews and investigations
- enabling the reviews to inform one another where that is consistent with their process.

How might you know if you are meeting this quality marker?

1. Is there consideration of any parallel processes in the terms of reference/scoping document?
2. Is there an early discussion between the police/ Crown Prosecution Service (CPS) and the SCR and where necessary a face-to-face meeting?
3. Is notification made to the coroner at an early point when a child has died and a review is being conducted?

4. Is there correspondence between all the relevant reviews showing efforts to achieve the best fit for the circumstances?
5. Are notes of interviews and meetings and copies of reports that might be considered relevant to criminal proceedings retained?
6. Does the business unit have an index of material generated by the SCR which might be disclosable?
7. Is it clear who owns these documents so that the relevant body can make judgements on their disclosure?
8. Does the final report acknowledge any interaction with other reviews and any impact on the SCR?

Knowledge base

- Practice experience of negotiating interaction between parallel processes when conducting SCRs suggests this is a complex area that can create significant challenges to the SCR.

Link to statutory guidance and inspection criteria

- NHS England 'Serious incident framework' (2015).
- 'Guidance for coroners and Local Safeguarding Children Boards on the supply of information concerning the death of children' (Ministry of Justice, 2010).
- 'Liaison and information exchange' (National Policing Homicide Working Group 2014).
- CPS/Association of Directors of Children's Services (ADCS) 'Protocol and good practice model' (2013).

Tackling some common obstacles

- Early discussion with the police is helpful as views of police officers, the CPS and prosecuting counsel vary as to the constraints that should be placed on SCRs and their willingness to negotiate.
- As the range of parallel investigations and reviews is large and the circumstances of individual cases vary greatly, solutions have to be developed by the LSCB without clear precedent or experience to draw on.
- There is discretion in the SCR methodology that can cause uncertainty for those conducting other reviews, which is why early discussion is helpful.

Serious Case Review Quality Markers

Supporting dialogue about the principles of good practice

Quality Marker 10: Assembling information

Quality statement: the Serious Case Review (SCR) gains sufficient information to underpin an analysis of the case in the context of normal working practices and relevant organisational factors

Rationale

The purpose of an SCR is to learn from past professional practice to support improvements in future safeguarding. This requires an analysis that evaluates and explains professional practice in the case, shedding light on routine challenges and constraints to practitioner efforts to safeguard children. The organisational factors that helped and hindered timely help to families and protection of children need to be ascertained. This requires a wide range of information types to be gathered including:

- The facts of what happened in the case – who did what, and when?
- The rationale for decision-making, action and inaction – why did people do what they did, what were they trying to achieve, what was influencing their practice?
- How normal was their behaviour – is this the way things are usually done?

The sources of such information are varied including:

- formal records, paper-based and electronic
- practitioners and managers who were involved in the case or potentially should have been
- senior managers and leaders responsible for strategy and its operationalisation
- the child(ren), young people and family members as well as friends and community where relevant and appropriate
- documents that explain how services were then or are currently provided (procedures, policy documents, audits, inspection reports etc.)
- ICT systems and processes used.

A range of different techniques exist through which to engage with these different types of information and make best use of what they can provide.

What is a sufficient amount of information will vary. All reviews aim to be proportionate, which means that different reviews will require different amounts of information assembled to achieve their aims. Different commissioners and different models vary in how much they aim to clarify whether any problematic practice identified in the case was more widespread at the time. Similarly, only some models set out to assess the current relevance of past practice issues identified in the case being reviewed. Information needs may also change as the analysis progresses.

How might you know if you are meeting this quality marker?

1. Has there been discussion about what information needs to be requested and what level of detail is required, relative to decision-making about the proportionality and other commissioning specifications of the review?
2. Has guidance been provided to LSCB members about what information is requested at the beginning of the review, and the level of detail required, and why?
3. Have all potential sources of relevant information been considered?
4. Has access been arranged for the lead reviewer(s) and relevant others to all the different sources of information deemed relevant?
5. Are the methods being proposed for assembling the information appropriate to the nature of the different information sources and the commissioning specification of the SCR?
6. Does the structure of the SCR enable direct input by practitioners and managers (e.g. interviews, group meetings)?
7. Is there transparency about any reasons for non-cooperation by LSCB members?

Knowledge base

- Using a range of types of information, including softer data such as the views and experiences of those involved, is an established principle of effective investigation across domains. This is supported by practice experience of conducting SCRs.
- Recent Department for Education (DfE) commissioned research into barriers and facilitators to learning supports practitioners' involvement in SCRs as improving learning (Rawlings et al., 2014).

Link to statutory guidance and inspection criteria

- Para 11, p 74 of 'Working together' (HM Government 2015) provides details about how SCRs and other case reviews should be conducted.

Tackling some common obstacles

- Moving beyond individual errors in practice to understand systemic problems means that it is not necessary to examine every aspect of practice in equal depth.
- Understanding exactly the form and focus of the SCR that has been commissioned and the rationale will help people to understand the type and amount of information being requested.
- Expertise in research methods can help in generating the right type of data from the different sources.
- Heightened group work skills are often needed to minimise the risk of harm being done through engaging with staff.
- Where there is consensus about the need for an SCR, member agencies' contribution to the review is improved.

- Clarity about whether information is gathered for the purpose of the SCR or to enable individual agency learning supports open engagement.
- Flexibility about the best means of obtaining practitioners' views can help address the issue of staff movement (e.g. using Skype for interviews if a professional has moved abroad).
- People can be inhibited from sharing information if they think that to do so would have negative consequences, this is best addressed by developing a culture of learning from mistakes without blame.
- Agreeing governance arrangements for cases that cross multiple borders helps with enabling access to all necessary information.

Serious Case Review Quality Markers
Supporting dialogue about the principles of good practice
Quality Marker 11: Practitioner Involvement

Quality statement: the Serious Case Review (SCR) enables practitioners and managers to have a constructive experience of taking part in the review

Rationale

Practitioners and managers who were involved in the case, or potentially should have been involved, are an important source of information for an SCR. Their input is critical to understanding why individuals acted as they did and what was influencing their practice, including routine ways of doing things. How they experience being involved is important. SCRs can be frightening and threatening and employers have a duty of care to all staff, which requires them to provide adequate support. Individual learning is also enhanced by practitioners having a positive experience of contributing to the SCR. The broader learning and improvement culture of an organisation is strengthened by good feedback from practitioners who have been constructively involved in an SCR. Therefore the SCR needs to enable those involved to have a constructive experience of taking part.

How might you know if you are meeting this quality marker?

1. Is the purpose of any interviews, conversations, meetings or events that involve practitioners clear?
2. Are participants being provided with clear information about the SCR and their role in it?
3. Are agencies encouraging their staff to contribute their experiences and views to the SCR?
4. Does the planning for the SCR include consideration of how to support individual practitioners? For example, those who played key roles in the case, or who are not part of core Local Safeguarding Children Board (LSCB) agencies, or are from agencies rarely involved in SCRs.
5. Are practitioners being provided with adequate protections within their own organisations?
6. Are practitioners being provided with adequate support and protection in the planning of any group events?
7. Has there been adequate consideration of whether there are any implications of the review for people now in senior management positions and if anything needs to be done to support them?
8. Are there plans to gather feedback from participants about their involvement?

Knowledge base

- Department for Education (DfE) funded research on SCRs has shown that practitioners welcome the opportunity of being directly involved in SCRs (Rawlings et al., 2014).
- Lead reviewer experience highlights the dangers of practitioner events that are not clear about purpose and function.
- Research in the use of root cause analysis in health suggests that staff tend not to participate readily if they don't think genuine learning will emerge (Nicolini et al., 2011).

Link to statutory guidance and inspection criteria

- 'Working Together' (HM Government 2015) requires that 'professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith' (p 73).

Tackling some common obstacles

- Where there is clarity about the purpose of practitioner interviews, conversations, meetings and/or events it is easier to manage any tensions for individuals.
- Participating in a group may be experienced positively but can present some individuals with challenges linked to their role in the case being reviewed, and this needs to be considered and addressed.
- Where staff have previously had positive experiences of practitioner events it is easier to achieve a constructive experience.
- The stronger the open learning culture of agencies, the easier it is for senior managers to support practitioners to engage openly in the process.
- The expertise of the lead reviewer(s) in handling complex group dynamics helps minimise risks associated with group events.
- Agencies may indicate a formal 'sign-up' to the principles of openness but it can be more difficult to achieve full commitment from all managers, and this needs to be considered when planning practitioner events.

Serious Case Review Quality Markers
Supporting dialogue about the principles of good practice
Quality Marker 12: Family involvement

Quality statement: the Serious Case Review (SCR) is informed by 'family' members' knowledge and experiences relevant to the period under review

Rationale

Family members are an important source of information about how services were experienced in an individual case and may provide information about service delivery in general. In this context, the definition of family can be broadened to include wider family and networks where this is judged to be necessary and proportionate to the likely learning. Publication of SCRs places a greater onus on the Local Safeguarding Children Board (LSCB) to ensure that personal data placed in the public domain is accurate and involving family members may facilitate this. However, it can be entirely appropriate for family members to decide not to take part.

How might you know if you are meeting this quality marker?

1. Is there clarity about why family members are being involved?
2. Has there been discussion about which family members are involved and why?
3. Is it agreed how family members are being supported to be involved?
4. Do the family have the opportunity to influence the focus of the review?
5. Is there clarity about what the family is going to be asked?
6. Has there been discussion about how the analysis will be informed by family members' knowledge and experiences relevant to the period under review?
7. Has there been discussion about how families are to be represented in the final report?
8. If family members are not involved, are the reasons for non-involvement reasonable and are they documented?
9. Are there mechanisms to allow the family to feedback on the report before it is completed?

Knowledge base

- Recent research into family involvement in SCRs identified four reasons for family involvement: human rights; a child-centred perspective; a primary source of knowledge and information; altruistic and cathartic motives (Morris et al., 2013).
- The questions above draw on research conducted by Professor Siobhain Laird, University of Nottingham.

Equality and diversity

- The needs of families where English is not a first language may require specific interventions and may require interpreting and translation.
- Disabled parents may also require additional support.
- Consideration of the particular needs of children (siblings) may be required.
- In order to involve adolescents, a range of methods for communication can be considered including email/text/Skype/Facebook.

Link to statutory guidance and inspection criteria

- 'Working Together' states that 'families, including surviving children, should be invited to contribute to reviews. This is important for ensuring that the child is at the centre of the process' (HM Government, 2015: p74)

Tackling some common obstacles

- Identifying the support required for children to enable their involvement, and the expertise professionals may need to communicate with them in this context, helps to address fears that agencies can have about participation impacting negatively on the child.
- Clarity about confidentiality and how their input will be represented can support participation in the SCR where family members are fearful of repercussions from wider family or community.
- Additional support can also enable family members to be involved where there are issues such as domestic abuse.
- Specialist organisations, such as the Victoria Climbié Foundation of Advocacy After Fatal Domestic Abuse (AFFDA), provide something akin to mediation services that help to facilitate a constructive dialogue between families and agencies.
- The ability of lead reviewers to analytically address contradictory views expressed by different family members and/or between family members and professionals helps enable meaningful involvement of family members. Expectations that the final report will produce a definitive account can make it more challenging to accommodate differing perspectives.

- Where it is decided not to involve family members in the SCR until after civil and/or criminal proceedings are concluded, anticipating the extra analytic work involved in amending the analysis so that it is informed by their input can avoid their involvement being only tokenistic.
- Where there are criminal investigations and family members are witnesses or suspects, involving the senior investigating officer at an early point, and enabling them to understand the focus and scope of the review, is essential. It allows informed discussions about when and how family members can be involved and supports access to any relevant information.

Serious Case Review Quality Markers

Supporting dialogue about the principles of good practice

Quality Marker 13: Analysis

Quality statement: the Serious Case Review (SCR) analysis is transparent and rigorous. It evaluates and explains professional practice in the case, shedding light on routine challenges and constraints to practitioner efforts to safeguard children

Rationale

The purpose of SCRs is to support improvements in safeguarding practice. This means it is not sufficient to describe professional activity in a case or to identify elements of practice that were problematic, without explaining why they occurred. The analysis needs to identify what has led to and sustained the kind of practice problems that the case reveals, so as to focus improvement efforts. This requires the following.

- Relevant aspects of work with the family are explored and evaluated, and this assessment utilises appropriate research evidence about good practice, and references available guidance, relevant legislation and professional requirements. Those leading the review minimise the influence of hindsight and outcome bias on the evaluation of practice.
- The SCR analysis attains an understanding of professional practice. It provides an explanation of what influenced professional activity and decision-making at key points in the management of the case. The analysis utilises available frameworks of 'human factors' in the safety management literature so that the interaction of individual, human, cultural and organisational aspects is assessed.
- The SCR's conclusions stem from the analysis of the individual case but highlight underlying strengths and weaknesses in how service delivery across similar cases worked more generally and routinely. The analysis is informed by an understanding of how complex systems function.
- Findings/recommendations are prioritised according to the areas of greatest need for improvement. This interpretation can be strengthened by addressing whether the same kinds of practice problems still occur and by utilising information from sources other than the individual case, including performance data.
- There is rigour to all aspects of the analysis process. The methods used are clear and transparent, drawing on knowledge in the research methods literature.

How might you know if you are meeting this quality marker?

1. Is the approach to analysis contained in the QM understood by those who commission and undertake the review?

2. Is it clear from any descriptions of the method/approach used for the SCR that it enables the approach to analysis described in the rationale section of the QM?
3. Has the analysis established what happened in the case, with comments on the quality of practice but also explanations of professional actions and decision-making?
4. Is the research evidence about what constitutes good practice that is used in the analysis up to date and accurate?
5. Does the analysis provide explanations of professional behaviour that call on a range of factors related to the tasks, tools and organisational issues rather than only being concerned with whether staff were adequately skilled and the relevant procedures were available?
6. Is it clear what specific techniques have been used to minimise the bias of hindsight and outcome knowledge on the analysis?
7. Does the presentation of the analysis in both working documents and the final report show enough of the working-out process to allow the interpretation to be critiqued and counter evidence to be brought to bear?
8. Does the analysis draw attention to what professional activity in the case reveals about how service delivery worked, or is working more generally and routinely?
9. Is it clear where knowledge about the wider safeguarding system at the time of the case, or now, has come from? For example, working with a review team, input about practitioners' wider experiences.
10. Does the analysis show clearly how the conclusions relate to the individual case as well as why they are relevant to wider safeguarding practice?
11. Does the lead reviewer(s) access supervision or peer challenge to support the quality of analysis undertaken?

Knowledge base

- Methods of accident investigation in other sectors rely on an explicit model of 'why things go wrong' as a framework for analysis of material. These frameworks generally involve the identification of areas of practice that were below expected standards of quality and timeliness. They distinguish between particular combinations of 'contributory factors' that influence a specific course of events, from 'latent conditions' that affect all professional activity (e.g. Reason, 1997).
- 'Human factors' is an established field of study aimed at understanding how people perform in different circumstances, by looking at the interaction of individuals at work, the task, tools and equipment they use and the environment in which they work. Human factors knowledge has been applied across a wide range of industries and settings to underpin improvements in performance and safety.
- Research in health promotes the benefits of investigations of incidents, providing a 'window on the system' rather than only identifying the cause of the particular incident being reviewed (Vincent, 2004).
- Hindsight bias is the tendency to 'consistently exaggerate what could have been anticipated in foresight' (Fischhoff, 1975) and is a well reproduced research finding.

Outcome bias is an element of this whereby we judge decisions or actions that are followed by a negative outcome more harshly than if the same decisions or actions had ended either neutrally or well. Blaming bad outcomes on simple causes such as human error can literally seems to make sense because knowledge of the outcome changes our perspective so fundamentally (Woods et al., 2010).

Link to statutory guidance and inspection criteria

The 'Working Together' guidance (HM Government 2015) supports the bullet points of the rationale. It states that SCRs should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight
- is transparent about the way data is collected and analysed
- makes use of relevant research and case evidence to inform the findings (para 11, p 74).

Tackling some common obstacles

- Determining what is good and poor practice is easier for lead reviewers when working with a review team of senior managers from relevant disciplines.
- There is not always a strong research evidence base about good practice, nor consistency of expectations across agencies, so discussion and judgement are often necessary.
- SCR analysis is more complicated when the case involves a large number of children and/or professionals. Planning in advance how this will be approached is helpful.
- It is useful to discuss the possibilities of supervision with lead reviewers as there is no standard structure for this provision.
- Clarity about the extent to which the aim of the SCR is to assess whether any problematic practice was more widespread at the time, and the current relevance of underlying reasons for past practice issues identified in the case, enables the boundaries of the task of analysis to be clear and agreed by all.

Serious Case Review Quality Markers
Supporting dialogue about the principles of good practice
Quality Marker 14: The report

Quality statement: the report clearly identifies the analysis and findings of the Serious Case Review (SCR) that are key to making improvements, while keeping details of the family to a minimum. Findings reflect the explanations for professional practice that the analysis has evidenced

Rationale

The main function of the report is to make accessible the SCR analysis, in order that it can support necessary improvement work. Descriptions of practice problems are not therefore sufficient. Instead, findings/recommendations need to reflect the explanations of professional practice that the analysis has identified, if learning and improvement are to result. These need to be easily identifiable so others can use them. Making the working-out process transparent helps in evidencing the findings so their validity does not need to be taken on trust. Such a presentation can also increase public accountability and supports public trust.

The Local Safeguarding Children Board (LSCB) also has the statutory responsibility for publishing the report in a format, without redaction, that will not be likely to cause harm to any child or vulnerable adult involved in the case. A key part of this is protecting their privacy. There is often other information on the case in the public arena, for example media coverage and anonymised family court reports. The information is usually readily accessible via the internet. This makes it difficult to include in the SCR report any personal data or precise identifiers, such as the exact chronic health condition, without the risk that it makes the family identifiable, or reveals personal or sensitive information about them to those who can already identify them. Consequently, personal and sensitive information about family members should not be included and precise details about the case should be minimised. This does not prevent detailed descriptions of professional actions and contexts that are often needed to explain practice problems and evidence findings.

How might you know if you are meeting this quality marker?

1. Does the structure of the report make it straightforward to identify relevant analysis and findings, so as to assist other local areas to identify learning that is pertinent to them and to assist the collation of learning at a national level?
2. Does the amount of information provided in the report satisfy the need for privacy of family members and individual staff while providing sufficient information to make accessible the SCR analysis, in order that it can support necessary improvement work?
3. Does the report contain findings and/or recommendations that reflect the areas deemed as priority for improvement?

4. Do these findings and/or recommendations address explanations of practice or remain only descriptive of issues identified in how professionals handled the case?
5. Is there transparency in how conclusions have been reached?
6. Does the report adequately manage accessibility and explaining complex professional and organisational issues?
7. Is the tone and choice of words appropriate to the review?

Knowledge base

- Learning into Practice Project (LIPP) research on SCR reports (2016) has identified that it is often very difficult to pinpoint 'analysis and findings' in SCR reports and that this presents challenges for enabling national learning from individual SCRs.
- LIPP research on SCR reports (2016) notes how common it remains for such reports to remain purely descriptive of the case.
- Ascertaining the effects of the full publication of SCR reports that contain detail about family members and their circumstances on those family members is challenging. For children concerned the effects may occur in the distant future.

Equality and diversity

- Concern about impact on vulnerable family members of publication.

Link to statutory guidance and inspection criteria

- 'Working Together' (HM Government, 2015: p79) provides guidance about publication. This includes stating that 'From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case'. It states that final SCR reports should:
  - provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence
  - be written in plain English and in a way that can be easily understood by professionals and the public alike
  - be suitable for publication without needing to be amended or redacted.
- The annual reports from the National Panel of Experts provide additional direction about the content of SCR reports. This direction includes stressing that reports 1) capture lessons for the services concerned, that focus on what caused things to happen at critical points in the management of the case; and 2) do not include detail that is not relevant to that learning (e.g. blow-by-blow accounts of what happened to the child). They also emphasise that reports be succinct and accessible (National Panel of Independent Experts on Serious Case Reviews, 2014, 2015).

Tackling some common obstacles

- Explaining what happened in a case and why, as well as protecting the privacy of family members involved in the case, are two tasks that are somewhat at odds with each other. The more you do of one, the less you can do of the other. Acknowledging this tension can help to address anxieties about whether the report is compliant with statutory requirements.
- The drive to produce SMART recommendations (specific, measurable, achievable, realistic and time-bound) can deter from a full exploration of practice problems that are complex and for which there are no easy solutions.
- Balancing the need for individual confidentiality with providing sufficient information to understand the rationale for changes recommended to professional practice is challenging for lead reviewers. They may be assisted by editorial support.
- Small geographic areas present real challenges to the possibility of anonymising the family if saying anything specific about the case.
- Different, often contradictory, advice exists as to what constitutes a ‘good’ report. Acknowledging this can bring clarity to discussions.
- Open discussion with the lead reviewer about the nature of the final report, as part of the process, helps avoid misunderstandings and repeated rewriting at the final stages of the review.

Serious Case Review Quality Markers

Supporting dialogue about the principles of good practice

Quality Marker 15: Improvement action

Quality statement: robust, informed discussion by agencies underpins agreements about what action should be taken in response to the Serious Case Review (SCR) report

Rationale

For an SCR to support improvements, the response of the Local Safeguarding Children Board (LSCB) and member agencies is as important as the report. The response of the LSCB may entail actions in relation to each of its broad statutory functions: to coordinate what is done to safeguard to children and to monitor and challenge the work of member agencies.

The actions of the LSCB can range from the strategic to the immediate and practical. Working out what to do is not necessarily self-evident or straightforward and so requires discussion. Judgements need to be made in light of the urgency of addressing the problems identified, relative to improvement activity already underway. Therefore discussion is required before informed agreement can be reached.

Some improvements require agencies to act collaboratively to achieve them. This will be facilitated by joint discussion of the issues and shared prioritisation of the response. Some improvements will require national action.

How might you know if you are meeting this quality marker?

1. Does the LSCB have a coherent mechanism for managing discussion about the actions needed to respond to the SCR?
2. Is there clear leadership from the chair and key agencies about the need for an open and mutually challenging discussion about what is said in the report about the effectiveness of the safeguarding system and its component parts?
3. Is appropriate time been given to receive and respond to the report (e.g. holding an extraordinary board meeting or other mechanisms)?
4. Is the LSCB being supported to link discussions about the SCR response to the learning and improvement framework and LSCB business plan? For example, is the board being provided with relevant information already identified through its learning and improvement framework?
5. Has the LSCB prioritised its response by linking to the learning and improvement framework and LSCB business plan (note that it can be legitimate to delay, given the priority areas already identified)?

Knowledge base

- We have not been able to identify any relevant research base or practice knowledge for this quality statement.

Link to statutory guidance and inspection criteria

- 'Working together' requires that LSCBs agree what action should be taken and produce a response when the SCR is published (HM Government, 2015: 79, 80).

Tackling some common obstacles

- Having a clear, considered process helps to avoid the LSCB response being rushed and at the last minute.
- Allocating sufficient time to enable meaningful discussion at the LSCB meeting can assist in avoiding organisational defensiveness. Some LSCBs arrange extraordinary meetings for the SCR to avoid pressures on busy meeting agendas.
- Where the SCR sub-group or equivalent does most of the discussion and development of the response, there is a need to consider how the LSCB is supported to be actively involved and own the decisions.
- An LSCB learning and improvement framework that is structured to support the integration of learning from different sources and also prioritises and manages that learning will enable an informed discussion about the response.
- Having a model for change management can help LSCBs think more broadly about mechanisms for change beyond training of frontline staff and writing or amending procedures.
- The development of a plan of engagement activities with different audiences ranging from practitioners to strategic leaders can be more effective than more generic dissemination activities.

Serious Case Review Quality Markers

Supporting dialogue about the principles of good practice

Quality Marker 16: Board written response

Quality statement: the board agrees a written response ready for publication that explains, clearly and succinctly, what action should be taken in response to the Serious Case Review (SCR) report

Rationale

Capturing in writing the conclusions of board discussions about the Local Safeguarding Children Board (LSCB) response to the SCR supports accountability, and therefore public trust that lessons will be learnt.

A written response provides the opportunity to set the SCR findings/recommendations in a broader context by describing where it fits in the bigger picture the LSCB has of practice locally. Depending on the model used for the SCR, the extent to which an SCR assesses how practice in the case relates to the way things are now varies. So the response is an opportunity for the LSCB to articulate where it thinks practice is currently and what has changed. By this means, the response provides contextual information that helps explain what is going to be prioritised, and what the LSCB is going to do to address the issues.

How might you know if you are meeting this quality marker?

1. Has sufficient time been scheduled to develop the written response, after the report has been presented to the board, before publication?
2. Is the LSCB response written in plain English?
3. Does the LSCB response (which may take a number of forms) explain whether the board accepts the findings of the review?
4. Does the LSCB response explain any priorities for action and how they fit within the broader learning and improvement framework?
5. Does the LSCB response say what action the board and its member agencies will take?
6. Does the LSCB response say how it proposes to monitor the effectiveness of any action that will be taken?
7. Does the LSCB response include national recommendations where necessary?

Knowledge base

- We have not been able to identify any relevant research base or practice knowledge for this quality statement.

Link to statutory guidance and inspection criteria

- ‘Working together’ requires that LSCBs agree what action should be taken and produce a response when the SCR is published (HM Government, 2015: 79, 80).

Tackling some common obstacles

- SCRs that identify the need for systemic changes require executive agreement and action which requires that LSCBs move away from previous custom and practice which has been to focus action exclusively on frontline practice.
- It is necessary for monitoring and evaluation of actions to be built in from the beginning, otherwise they may be overlooked.

Serious Case Review Quality Markers

Supporting dialogue about the principles of good practice

Quality Marker 17: Publication

Quality statement: decisions about whether, when and how to publish the Serious Case Review (SCR) report and response are made with sensitive consideration of the impact

Rationale

For the learning from an SCR to have impact beyond the local area, publication can be helpful and it is a statutory requirement.

Publication of the SCR report and the Local Safeguarding Children Board (LSCB) response can also enhance public trust and confidence in services by providing an understanding of what has gone wrong and why, and the actions that agencies are taking to improve services. Well conducted and presented reviews can also serve to improve public understanding of the complexity of work to safeguard children.

The longer the delay in publication, the more likely the learning will be out of date. However, parallel criminal and investigatory processes can provide additional information pertinent to the accuracy of the SCR and the learning generated, requiring publication to be delayed until their conclusions are reached. Publication prior to the completion of parallel criminal and investigatory processes can also have an impact on those legal proceedings, including any inquest.

Publication can also expose details about the child concerned, siblings and other family members as well as professionals who worked with them, and create risks. These can potentially be mitigated if the report clearly identifies the analysis and findings of the SCR that are key to making improvements, while keeping details of the family to a minimum. It can also help to give consideration to whether, when and where the report should be published, and what support family members, foster carers and staff will need. Final decisions need to comply with the Data Protection Act 1988 and any other restrictions on publication of information, such as court rulings.

How might you know if you are meeting this quality marker?

1. Are genuine efforts being made to publish as soon as possible?
2. Are the professionals directly involved being informed of the contents of the report, of the schedule for publication and being given appropriate support?
3. When will the family have the report and are they being given appropriate support regarding its publication?
4. Is there a media strategy to support publication of the report?

Knowledge base

- We have not been able to identify any relevant research base or practice knowledge for this quality statement.

Link to statutory guidance and inspection criteria:

- 'Working together' (HM Government, 2015: 79) requires all SCR reports to be published. It also requires (p 80) LSCBs to publish, either as part of the SCR report or in a separate document, information about: actions which have already been taken in response to the review findings; the impact these actions have had on improving services; and what more will be done.
- The Office for Standards in Education (Ofsted) inspection guidance requires that good practice be disseminated and, where practice can be improved, SCRs are published.

Tackling some common obstacles

- If there are delays in publishing, because of parallel processes, it is important to plan how to advise all involved prior to publication. This may also require the LSCB response to be updated.

Serious Case Review Quality Markers

Supporting dialogue about the principles of good practice

Quality Marker 18: Implementation and evaluation

Quality statement: the Local Safeguarding Children Board (LSCB) integrates the learning from the Serious Case Review (SCR) and its decisions about how it is going to respond into its business plan and monitors actions to test whether improvements in services are being made

Rationale

A key function of the SCR is to improve professional practice. To achieve this the response of the LSCB and member agencies is as important as the report. Maximising the effectiveness of the response requires that actions are reviewed and outcomes evaluated. These should judge not only whether actions have been achieved but also whether they have made a difference to safeguarding practice.

The learning and actions emanating from an SCR are only one source of learning and improvement action, and feed into a bigger programme of work run and overseen by an LSCB. It is important that the action resulting from a single SCR is both seen and evaluated in the context of that bigger whole and as part of a continual learning process. In complex systems such as multi-agency safeguarding arrangements, the impact of change is often hard to anticipate with total accuracy and there may be unintended consequences. It is important therefore to ascertain whether the original response was the right thing or if the action needs adjusting.

How might you know if you are meeting this quality marker?

1. Does the LSCB have systems in place for reviewing whether action has been taken in response to SCR findings/recommendations?
2. Is the learning from this SCR going to be included and integrated into the learning and improvement framework?
3. Does the monitoring of the actions include both consideration of whether agencies respond but also what the outcome for children will be?
4. Is there going to be follow-up monitoring over time to check that change is maintained and if there are any unintended consequences?

Knowledge base

- Double-loop learning as described by ‘Learning to reduce risk in child protection’ in ‘The Munro review of child protection part one: a systems analysis’ (Munro, 2010).

Link to statutory guidance and inspection criteria

- The Office for Standards in Education (Ofsted) inspection guidance requires that SCRs identify good practice to be disseminated where practice can be improved.

Tackling some common obstacles

- Where monitoring the response to the SCR is an established part of the leaning and improvement framework, the SCR report is less likely to be treated as the end product rather than the response to the report's findings/recommendations.
- Where LSCBs have a number of SCRs underway it may be helpful to have a separate sub-group or equivalent that concentrates on evaluation and monitoring.
- Something akin to succession planning can help address the loss of ownership of SCRs when significant people leave or change role.
- When LSCBs are successful at prioritising their responses, it is less likely that their actions will be diluted by having committed to too much activity.
- The LSCB can help address the challenge of interdependencies between agencies in change processes.

Bibliography

Knowledge base

Berwick, D. 2013. A promise to learn – a commitment to act. Improving the safety of patient in England. London: Crown copyright 2013

Dekker, Sidney (2012-10-01). Just Culture: Balancing Safety and Accountability (p. 82). Ashgate Publishing Ltd. Kindle Edition..

Fischhoff, B. (1975) Hindsight & foresight: The effect of outcome knowledge on judgment under uncertainty. *Journal of Experimental Psychology: Human Perception and Performance,* 1 (2)**,** 288-299

Morris, K., Brandon, M. & Tudor, P. (2013) 'Rights, Responsibilities and Pragmatic Practice: Family participation in Case Reviews' *Child Abuse Review (2013) Published online in Wiley Online Library*

Munro, E., (2010) The Munro Review of Child Protection Part One: A Systems Analysis. Department for Education ed. London: The Stationery Office.

Munro, E., (2011) Munro review of child protection: interim report - the child's journey. *In* D.F. Education ed. London: Crowncopyright.

NHS England Patient Safety Domain. 2015. Serious Incident Framework. London: NHS England.

Nicolini, D., Waring, J. & Mengis, J. (2011) Policy and practice in the use of root cause analysis to investigate clinical adverse events: Mind the gap. *Social Science & Medicine,* 73 (2)**,** 217-225

Rawlings, A., Paliokosta, P., Maisey, D., Johnson, J., Capstick, J. & Jones, R., (2014) A Study to Investigate the Barriers to Learning from Serious Case Reviews and Identify ways of Overcoming these Barriers. London: Kingston University

Reason, J. (1997) *Managing the Risks of Organizational Accidents.* Farnham, Surrey: Ashgate Publishing Ltd.

The Chief Medical Officer, (2000) An organisation with a memory Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer. London: Department of Health

The Health Foundation: Patient safety resource centre (2013). http://patientsafety.health.org.uk/resources/incident-decision-tree (accessed 19/3/2016)

National panel of independent experts on Serious Case Reviews, (2014) *First annual report. . In* Department for Education ed. London: The Stationery Office.

National panel of independent experts on Serious Case Reviews, (2015) Second report of the national panel of independent experts on Serious Case Reviews. Department of Education: Crown copyright

Ofsted, (2008) *Learning lessons, taking action - Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008*. Ofsted.

Ofsted, (2009) Learning lessons from serious case reviews: year 2.[accessed 8/1/2015]

Ofsted, (2010) Learning lessons from serious case reviews 2009–2010. Ofsted.

Vincent, C. (2004) Analysis of clinical incidents: a window on the system not a search for root causes. *Quality & safety in health care,* 13 (4)**,** 242-243).

Woods, D., Dekker, S.W.A., Cook, R., Johannesen, L. & Sarter, N. (2010) *Behind human error. Second edition.* Farnham, Surrey: Ashgate.

Statutory and other guidance

Crown Prosecution Service & ADCS (2013) Protocol And Good Practice Model ("2013 Protocol") Disclosure Of Information In Cases Of Alleged Child Abuse And Linked Criminal And Care Directions Hearings

Department for Education, (2013) National panel of independent experts on Serious Case Reviews - Information for LSCBs and Chairs on how the panel will operate.

HM Government, (2015) Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children. London: Crown copyright 2015.

Ministry of Justice (2010) Guidance for coroners and Local Safeguarding Children Boards on the supply of information concerning the death of children. London: The Stationery Office

National Policing Homicide Working Group (Child Death sub group) (2014) Liaison and information exchange when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews - A Guide for the Police, Crown Prosecution Service and Local Safeguarding Children Boards.