Essex Safeguarding Children Board Serious Case Review Toolkit

(Including other types of Review)

October 2016

CONTENTS

Essex Safeguarding Children Board Serious Case Review Strategy

Introduction

This strategy sets out the arrangements by which the ESCB will conduct its case reviews. It highlights its statutory duties, overall process for running a serious case review and how the ESCB will commission such work.

This strategy should also be read in conjunction with the ESCB Learning and Improvement framework which sets out the role of SCRs in furthering learning and improvement of practice. Link to website as follows:

http://dnn.essex.gov.uk/Portals/67/Documents/Training/Learning%20and%20Improvement%20Framework%20Jan%2015.pdf

The core process that the ESCB will utilise for all case reviews is set out in the attached Model for conducting Serious Case Reviews document (page 9)[1]. It is understood that this process will be flexible depending on the nature and complexity of the case.

It should also be noted that the Board is concerned with reviews of significant cases, some of which will become SCRs and others may become reviews that will not meet the threshold but will be commissioned by the Board when considered necessary.

The key aim of any review remains as set out in Working Together 2015:

The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

National Context

The ESCB will conduct all its case reviews in line with process and principles prescribed by Chapter 4 of Working Together March 2015.

- there should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;
- 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;
- 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

[1] This process is based on the model employed by Suffolk LSCB

be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process;

- final reports of SCRs **must be published**, including the LSCB's response to the review findings, in order to achieve **transparency**. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections; and
- improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

SCRs and other case reviews 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; and
- makes use of relevant research and case evidence to inform the findings.

A decision to carry out an SCR will follow the requirements set out in Working Together to Safeguarding Children as follows:

Serious Case Reviews Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

"Seriously harmed" in the context of paragraph 18 below and regulation 5(2)(b)(ii) above includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

- a potentially life-threatening injury;
- serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. LSCBs should ensure that their considerations on whether serious harm has occurred are informed by available research evidence.

(The ESCB Independent Chair will give weight to medical and legal advice in such consideration).

Cases which meet one of the criteria (i.e. regulation 5(2)(a) and (b)(i) or 5(2)(a) and (b)(ii)) **must always** trigger an SCR. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide. Where a case is being considered under regulation 5(2)(b)(ii), unless there is definitive evidence that there are no concerns about inter-agency working, the LSCB **must** commission an SCR.

In addition, even if one of the criteria is not met, an SCR **should always** be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or secure children's home. The same applies where a child dies who was detained under the Mental Health Act 1983 or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.

Deciding whether to convene a SCR Consideration Panel

The SCR Sub-Committee is made up of representatives from ESCB partner agencies. There is an expectation that all Sub-Committee members will ensure that they attend the meeting to share initial information and to assist in the shared decision making. Due to the complexity of health organisations, the relevant initial health information will be gathered from the health provider(s) involved with the child and family
It is paramount that legal representative/s are linked into the process.

It is the responsibility of the SCR Sub-Committee members to consider whether the presenting information meets the criteria for a SCR Consideration Panel to be convened in accordance with the criteria set out in Working Together 2015.

In some instances the SCR Sub Committee may consider Serious Incident referrals without a meeting taking place. If an SCR Consideration Panel is convened it will be expected to make a recommendation to the LSCB Chair.

The final decision on whether to conduct a SCR rests with the LSCB Chair.

Subsequently, the SCR Sub-Committee will quality assure the work of the SCR Consideration Panel /Review team as the review progresses and will ratify the final report before presentation to the ESCB.

LSCBs should consider conducting reviews on cases which do not meet the SCR criteria. If a SCR is not required because the criteria in regulation 5(2) are not met, the LSCB **may** still decide to commission a SCR or they may choose to commission an alternative form of case review. The LSCB Chair should be confident that such a review will thoroughly, independently and openly investigate the issues. The LSCB will also want to review instances of good practice and consider how these can be shared and embedded.

It should be expected that ESCB will take a proactive approach in commissioning such reviews which will be accountable to the Board. The Board therefore will have the same expectation of Partners in contributing to these reviews as in the case of formal SCR's

The LSCB should oversee implementation of actions /learning themes resulting from these reviews and reflect on progress in its annual report. It would be deemed good practice to publish the learning outcomes from other types of reviews.

Decision making process

The decision making process within the ESCB will be carried out in accordance with the local process as set out in the Guidelines for Decision Making (Appendix 1) taking into account the national guidance above.

Information sharing

It is understood that all agencies will share information to assist the review

Section 14B of the Children Act 2004 states that requests by the Local Safeguarding Children Board to supply information must be complied with if the following conditions are met:-

- That the request is made for the purpose of enabling or assisting the Board to perform its functions
- That the request is made to a person or body whose functions or activities are considered by the Board to be such that the person or body is likely to have information relevant to the exercise of a function by the Board
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In addition, the following quote from the GMC's guidance around child protection states:-

"You should …co-operate with requests for information about child abuse and neglect. This includes Serious Case Reviews set up to identify why a child has been seriously harmed, to learn lessons from mistakes and to improve systems and services for children and their families. When the overall purpose of a review is to protect other children or young people from a risk of serious harm, you should share relevant information, even when a child or young person or their parents do not consent, or if it is not possible to ask for consent. "

Partners and other relevant agencies should expect that the ESCB will take a proactive stance when applying this guidance to all reviews of significant cases commissioned by the Board .This includes the expectation that on occasion information may need to be provided without consent – this will also apply to information concerning parents or guardians when considered necessary.

In the case of any disagreement the Independent Reviewer will be expected to refer the concern without delay to the ESCB Business Manager who will liaise with an Executive level manager in the agency concerned .In the event that a resolution cannot be immediately

achieved the concern should be then escalated to the ESCB Independent Chair who will raise with the Chief Officer of the agency concerned.

Commissioning a review:

The ESCB will follow the guidance and checklist set out in Working Together 2105 for commissioning a review - this includes appointing independent reviewers as below:

The LSCB must appoint one or more suitable individuals to lead the SCR who have demonstrated that they are qualified to conduct reviews using the approach set out in this guidance. The lead reviewer should be independent of the LSCB and the organisations involved in the case.

The agreement with the overview writer/lead reviewer and the ESCB will also set the terms of reference for the review. These are to include –

- Questions to be explored as part of the review i.e. what do we want the review to achieve?
- How will the methodology be applied in this case – what if any amendments are needed?
- Roles and responsibilities and lines of communication between the ESCB and overview writer
- Timeframe for completion (NB this should be 6 months from commencement of the notification to OFSTED and the DFE)
- Ownership of the document, publication and process for review/amendment*
- Involvement of practitioners and the family consistent with the core systems methodology

*The Board will, at all times, seek to ensure that the integrity of an independently written review report is maintained. However the Board is also clear in its responsibility to ensure that reviews are completed in a wholly competent manner. Independent Reviewers and Report Writers should therefore expect to work with the quality assurance arrangements put in place by the Board via the SCR Sub Committee with the intention that review reports finally presented for the approval of the Board are fit for purpose. The ESCB will always reserve the right to accept or reject recommendations and also to make additional recommendations on any matters arising from the report

Methodology

The ESCB will adopt a systems approach for its reviews based on a core partnership learning review model. It is understood however that this model remains flexible to adapt to the details of the case and that a proportionate response will be considered for all cases. The precise details of methodology will be agreed with the lead reviewer, as will the terms of reference.

This is in line with guidance in Working Together 2015 which states:

LSCBs may use any learning model which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro. However the Board recognises that there may remain cases where further written information is required from agencies.

Timescales

All reviews to be carried out within 6 months of commissioning the review. Where there are delays, this will be communicated to OFSTED and DfE by the ESCB Board Manager.

Publication and learning

The review will be published in line with WT 2015. An action plan for learning will form a key part of the follow up for the review and all agencies will be required to ensure that these actions are implemented in their agencies and that the impact of these actions are monitored.

The overall action plan will be monitored via the ESCB Serious Case review sub committee.

The lessons from the review will be included in the ESCB learning and development programme. All agencies will also be required to disseminate learning within their own organisations.

Model for conducting

Serious Case Reviews

Introduction

This is a proposal for a process which can be used to conduct Serious Case Reviews and which is in keeping with the principles prescribed by Chapter 4 of Working Together March 2015.

These principles (contained in Paragraph 10) require: -

- A proportionate approach to a SCR, according to the scale and level of complexity of the issues being examined,
- All SCRs to be independently led
- Professionals who were directly involved with the case to be fully involved in the review process
- Families, including surviving children to be invited to contribute

In addition, Paragraph 11 of Working Together states that reviews 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 that data is collected and analysed; and
- Makes use of relevant research and case evidence to inform practice.

Two further aspects of effective Serious Case Reviews are:-

- Use of chronologies
- Organisational analysis

In this model, the key players are: -

Independent Lead Reviewer – This will need to be someone independent of the LSCB. This person will manage the process, chair meetings of the Review Team, facilitate the professionals' Learning Events, and in most instances also be the author of the Overview Report.

Dependent on the complexity of the case, there may be a requirement for a second independent person whose main role will be to be the **Author of the Overview Report**. This person will work closely with the Independent Lead Reviewer to manage and lead the Learning Event meetings with professionals.

The Review Team – which will be a small team (again dependent on the complexity of the case) but as a minimum would need senior managers who have multi-agency safeguarding experience and as a minimum would need a representative from Children's Social Care and Health, and a person who is able to represent the LSCB and keep the independent LSCB Chair informed of the progress of the Review. Members of the Review Team will assist the Independent Lead in facilitating the Learning Event and in providing local context and challenge as the analysis of professional practice and learning develops. It is recommended that Review Team members are not the same agency representatives who sit on the SCR Sub Committee..

Individual Agency Representative (IAR) (Chronology author) – Although this process does not require Individual Management Reviews to be completed, these persons will be responsible for the completion of the Individual Agency Chronology on behalf of their agency. This will be for the time period identified for the review, and the chronology template must include a column requiring objective comments, analysis and observations of practice taking place. The IAR will also be requested to provide a summary of their "comments" at the end of the chronology, identifying any themes that may have emerged and of any potential learning for the agency. The IAR must have had no line management experience in the case. An additional summary chronology will need to be completed covering the same time period, but in respect of any organisational change, significant events, staffing issues etc. which the organisation has experienced. This will assist with later consideration of any contextual issues that might have impacted on the services provided to the family. It must be made clear that this information will also be shared with other agencies as part of the Learning Event. An action plan will also be required to address any learning points.

Front Line Practitioners and Operational Managers directly involved in the case – will be invited to the Learning Event/s set up in relation to the case and will be actively involved in a collaborative and analytical process, with their involvement intended to make a significant contribution to the eventual development of Learning and Development from the case.

Members of the Family – will be engaged in the process in a similar way to the more traditional SCRs and will be asked to contribute via interviews with the Independent Lead/Overview Author. This would normally be done before the Learning event with the practitioners, so as the views of the family, if appropriate can be included within the

discussions and analysis of professional practice. It is recognised that other arrangements may be necessary to meet the particular needs of family members.

Where any incident is being investigated by the police and a member of the family is a victim, witness or on bail as a suspect the police representative who sits on the Review Team must liaise with the senior investigating officer with regard to obtaining the family's views or account. The ACPO policy must be complied with

(http://www.cps.gov.uk/publications/docs/liaison_and_information_exchange.pdf)

Stages of the Review process

This is a Summary Checklist of the different stages of the process with approximations of the timeframes within which they can be completed. This however will be dependent on the particular needs and complexities of the case. Greater detail of what the stages entail follows the Checklist**.**

Stage	Actions/Tasks	By whom	By when
	– Appoint Independent Reviewer in line with agreed ESCB Procedure		
1. Scoping Meeting	– Establish time period for the Review and broad themes for Terms for Reference – Discuss with Police re family contact before contact is made by agencies completing chronology – Set timetable for Review (to include meetings with family; Practitioners; Managers) – SCR Sub Committee to identify the agencies required to take part in order for them to nominate the right Review Team members. It is recommended that Review Team members are not the same representatives who sit on the SCR Sub Committee – Agree a pseudonym that will be used for the Review	SCR Sub Committee	Week 3
	- If required, letter sent to family members requesting disclosure of medical records	ESCB Support Team; Lead Reviewer	Week 5

	- Involved agencies' Chief Officers requested to: (a) identify chronology authors and provide contact details. (b) submit the following:- (i) chronology on ChronoLator template supplied; (ii)summary of identified themes and potential learning; (iii)action plan to address any learning points. (c) identify practitioners with direct involvement in the case and provide contact details (d) ensure commitment to enable chronology authors and practitioners to fully participate in the process		
2. Information collection and collation	- Review chronologies and summary comments	Independent Lead/Overview Author; Review Team; Chronology Authors; ESCB Support Team	Week 8
3. Establishing Key Themes for Analysis	- Finalise Terms of Reference - Develop and agree Key Themes for Analysis - Agree when and how family will be involved - Letter sent to families inviting meeting with ESCB Board Manager and Lead Reviewer	Review Team; Independent Lead/Overview Author; ESCB Support Team;	Week 8
4. Preparation for Learning Event	- Establish the structure and expected outcomes from the day - Composite chronology to be sent to all Learning Event participants with Guidance for Practitioners document - If further information is required Individual Management Reviews may be requested	ESCB Support Team	Week 11

	- Ensure appropriate participation of practitioners and first line managers - Review team members/ should identify practitioners and ensure that they are briefed and that support is in place both before and following the Learning Event	Review Team; Involved Agencies	
5. Learning Event	– Agree the facts of the case – Consider the child's lived experience – Undertake the work on the Key Themes – Identify Key Lessons Learned	Practitioners and Line Managers; Independent Lead/Overview Author; ESCB Support Team	Week 12
Overview Report – Draft 1 completed	By Independent Lead/Overview Author		Week 15
6. Meeting 5 Discuss Overview Report	– Consider the analysis and findings in the Overview Report – Are particular actions required for individual agencies? – Agree the main lessons learned from the Learning Event and confirm the Key Learning Outcomes	Independent Lead/Overview Author; Review Team; ESCB Support Team	Week 16
Overview Report – Draft 2 completed	By Independent Lead/Overview Author		Week 18
7. Meeting 6 Learning Event Practitioners feedback	– Findings from Overview Report presented to practitioners and operational managers for comment and further development as necessary.	Practitioners and Line Managers; Independent Lead/Overview Author; ESCB Support Team	Week 20
8. Meeting 7 Finalising the Report	– Final agreement re the Overview Report – Overall findings to be developed into priority areas for Learning and Development for attention by the LSCB – Report to be sent to involved agencies for factual accuracy checking – Report sent to LSCB Chair	Independent Lead/Overview Author; Review Team; ESCB Support Team	Week 22
Presentation to SCR Sub Committee	- Report considered by SCR Sub Committee for quality assurance and agreement	SCR Sub Committee	Week 24
9. Adoption by ESCB Board	- Presentation of key learning and themes to the ESCB	Independent Lead/Overview	Week 26

	- Final sign off of Report - Response and actions agreed	Author	
10. Lessons Learned and dissemination	- Feedback to family - Development of overall collated Action Plan - Dissemination of learning - Report and agreed ESCB media statement circulated to SCR Sub Committee and involved agencies 2 weeks before publication and to ESCB 1 week before publication. - Publication	SCR Sub Committee	Week 26

NB: This model is flexible and the number of meetings and level of information required will depend on the complexity of the case.

1. Scoping of the Review

1.1 Establishing that the criteria for a Serious Case Review has been met will be undertaken in line with the requirements in WT 2015 and following the ESCB decision making referral guidelines (Appendix 1). The SCR sub committee will also advise/agree with the LSCB Chair the detail of the Review process by which the SCR will need to be conducted. This will be reflected by the perceived complexity of the case.

1.2 The SCR sub committee will need to decide on the size and make-up of the Review Team with particular reference to whether there is any area of speciality or expertise that it would be useful to include in this team. Ideally however, this should be a small team who have broad interagency safeguarding experience at a senior level. It is recommended that Review Team members are not the same representatives who sit on the SCR Sub Committee

1.3 There will be the need to appoint at least one independent person as the Lead Reviewer. If the case will require input from a large number of agencies and professionals, and has complex areas of analysis across different facets of safeguarding practice, potentially across LSCBs, then a separate independent Overview Report author will likely be needed.

1.4 Wherever possible, the time period to be covered by the review should reflect the potential learning that is to be achieved. To identify professional practice and procedures in the case that has since changed, will have little learning attached to it. Additionally with this process actively involving practitioners and their managers, the review period needs to be as short and as recent as possible. This needs to be balanced however with the need for example to understand the chronicity of child neglect and whether early help interventions could have been beneficial.

1.5 All those agencies who provided services to the family for the time period to be covered by the Review will need to be formally requested by the LSCB Chair, to

appoint their Individual Agency Representative to complete a chronology of their agency's involvement, and of any organisational changes over the same period of time, which may have impacted on front line practice. A chronology template will be provided. Agencies will need to be advised that chronologies will be shared with other agency chronology authors, practitioners and the Review team.

1.6 Agencies will also be required to provide a summary of their comments made in the chronology identifying any themes that may have emerged and any potential learning for their agency, together with an action plan to address any learning points.

2. Information collection and collation

2.1 The work of the Review Team, chaired by the Lead Reviewer, begins once the chronologies have been completed and have been amalgamated. The team will need to be satisfied that the appropriate level of information has been provided by each agency and that the "comments" section of the chronology, and the summary of these, provides useful insight and commentary on the actions undertaken by the agency and of possible learning for that agency. This piece of work will need to be signed off by a Senior Manager from the organisation.

2.2 If necessary, the Review Team may decide to either request more information from an individual agency, or ask the author of the chronology (the IAR) to attend a meeting if further clarity is needed about their agency's role with the child and/or family.

3. Establishing the Themes for Analysis

3.1 By studying the chronologies and considering the commentaries provided within them, the Review Team will need to discuss the case in detail and develop what they consider will be the Key Themes for Analysis. These should be as few as practicable and ideally should not number more than six or seven. They should also not be set in stone as once the Learning Event begins, these may well adapt and change. Nevertheless, these key themes will be an important foundation to the work of the Review and do not need to pose specific questions as with previous SCRs, but raise issues of practice that have emerged within the case, but can be transposed into working with families more generally and give insight into the systems which operate formally or informally within safeguarding practice. Some examples might be "the challenge of engaging families in effective interventions", "the ability to use assessments to inform future interventions" etc.

3.2 The Independent Lead will also need to produce a short "key events" document (2 sides maximum) taken from the amalgamated chronology, which will act as a reference document throughout the work undertaken in the Learning Event and provide information to the participants prior to their attendance. If desirable, the identified Key Themes for Analysis could also be shared prior to the meeting.

3.3 The Review Team will need to decide upon how and when the family will be afforded the opportunity to contribute to the review. Ideally this should take place before the Learning Event, so as the family's views can be included within the day so as it can add in the most appropriate way to the development of the understanding and analysis of professional practice at the end.

4. Preparation for the Learning Event with practitioners.

4.1 The Review Team will need to be clear that they have a full list of appropriate professionals and line managers to invite for the Learning Event. This will need to be obtained from the Individual Agency Representatives who compiled the chronologies. The criteria for the professionals to be invited will be that they would have had some form of direct operational involvement with the child and family. It is particularly important that the most appropriate professionals attend. Requests for staff to attend who have not had direct involvement with the family should not normally be agreed, as this could unhelpfully impact on the dynamics of the group.

4.1 The letter of invitation should come from the LSCB Chair, give plenty of notice, explain the purpose of the event, format, feedback process and to give it the highest priority. Also in consultation with Individual Agency Representatives, it may be valid for a member of the Review Team or the Independent Safeguarding Lead to have a pre-meeting with certain practitioners. This could be for a range of reasons but the purpose would be to enable the individual to contribute positively to the multi-agency work at the Learning Event, and not be hampered by any concerns about a blame culture developing or that there would an inappropriate focus on individual practice. It is recognised that in cases of child deaths, some professionals may feel vulnerable, upset or anxious and that a pre-meeting could help to allay those understandable fears and allow them to contribute fully at the Learning Event.

4.2 Review team members should identify practitioners and ensure that they are briefed and that support is in place for both before and following the Learning Event. Please see appendix 4

4.3 If there are likely to be key absences from the Learning Event, then steps should be taken by the Review Team to separately gain their contribution as soon after the Learning Event as possible.

4.4 There may be occasions when the conduct of a review needs to take into account ongoing investigations (Police) and potential legal proceedings. In this regard the ESCB has adopted the recent guidance note of the ACPO/CPS and any concerns in the ongoing conduct of a review and/or publication will be a matter for the Boards legal adviser to resolve with the Police and CPS in full consultation with the ESCB Independent Chair who will reserve the right to make the final decision which will be binding on all agencies.

5. Review – Learning Event 1

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

- For front line practitioners and operational managers to participate in the inter agency review of this case following a systems methodology, and in doing so;
- To discuss and agree the factual information compiled about the family in terms of incidents and professional interventions, and to gain agreement or additions/changes to these,
- To work alongside the Review Team to undertake analysis of the professional practice from the key themes which have emerged in respect of the case
- To identify the key learning themes from the analysis and,
- Identify how the experiences of this case could be used to further develop local inter agency safeguarding practice

5.2 The structure of the Learning Event must begin with establishing and agreeing the facts of the case. (See Appendix 2 for a proposed structure) Each participant will have had a copy of the Key Events summary and within the session it will be important to have the Integrated Chronology (colour coded per agency preferably) either displayed around the room or as a resource for reference within the meeting. (However this should be a copy of the chronology without the "comments" section, as this may unhelpfully direct views of participants before they have been able to provide objective input from their direct experiences with the family). It will then be for the participants, in multi-agency groups preferably, to share and discuss the content of the factual information and to add, question as necessary the information being presented. It may be that as a result of this exercise that some of the factual information will need to be changed, but ultimately there should be a common understanding among the participants of the range and detail of the professional interventions and key events that the child and family had experienced.

5.3 With this knowledge, the group should then be encouraged to do some work looking at the "lived experience of the child/children". This would help participants to view the "story" of what happened with the family from the child's perspective which would help with developing a child focus to the later analysis of practice.

5.4 The next important part of the Learning Event is for the participants to work with the Review Team to develop the analysis of the case based initially upon the "Key Themes for Analysis", with some specific questions posed to help with addressing these (as suggested in Appendix 2).The meeting will need to give priority to the experience and views of the practitioners and managers present in order to develop consensus views (where possible) about not only what happened but why interventions or the lack of them occurred in the way that they did. There will need to be a flexible approach to enable professionals to be able to contribute to the key themes for analysis that are most applicable to them. Within this process it will be

essential that all actions and decisions, or lack of them by professionals, are viewed within the context of the systems which surrounded them and to what extent they were supportive or otherwise of the work with the family. It will be important that the Independent Safeguarding Lead assists the group in avoiding hindsight bias in their consideration of what took place with the family. In order to get to some of the detail about how and why certain aspects of professional practice took place in the way they did, it could be useful to identify which factors were impactful, and in particular whether they related to : -

- The family dynamics (e.g. difficulty in engaging the family, mobile family)
- Individual/Team practice (e.g. experience, knowledge and direction)
- Organisational/systems issues (e.g. staffing levels, procedural, culture of inter-agency working, organisational change, organisational expectations, management oversight and supervision)
- Community/environmental issues (e.g. local community strengths and weaknesses, local resources or lack of them, impact of racial and ethnic minority issues.),

  or probably the most likely,

- A mixture of some or all of the above

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

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

- Proactive (purposeful to address a problem and to generate change)
- Procedural (undertaken as part of a procedural requirement – e.g. statutory visit as part of a CP Plan, health development assessment)
- Reactive (in response to a request for help, referral, or to a crisis)
- Or to what extent they were a mixture of these three types of interventions….. will go some way to understanding the purpose and motivations for interventions which were carried out with the family. Once again these components of practice cannot be viewed without taking into account the wider systems which may have purposefully or inadvertently directed interventions to take place in a particular way.

5.7 The important issue is whether the mode of intervention reflected the needs of the children at the time. Some agencies, such as the Ambulance Service and the Police will tend to only undertake reactive interventions, whereas others are more likely to be a mixture of all three. The ability to successfully intervene with families which present different challenges, such as difficult to engage behaviours, will for

example largely depend on the type of professional intervention and its consistency. The predominant type of intervention may reflect individual style of a practitioner or particular profession, but just as likely to reflect organisational/team aims or culture and the level of resources available to deliver services.

5.8 The final part of the Learning Event (or potentially carried over into a second meeting in more complex or detailed cases) will be the development of the Key Lessons Learned. From the analysis of interventions and of how systems were enacted or otherwise in respect of the work with this particular family, then this will need to be transposed into areas of learning for professional practice in the future. It is essential that good practice is fully recognised so as this can be similarly developed for future learning. The outcome from the meeting will therefore be a list of key areas of learning that this case has identified which could make a positive difference in future safeguarding practice.

5.9 All the information and outcomes obtained from the Learning Event will provide the majority of the material to enable the Independent Safeguarding Lead/Author to complete the first draft of the Overview Report.

6. Overview Report (Draft 1)

6.1 With the information, analysis and lessons from the Learning Event, then the Independent person can complete the first draft of the Overview Report, including any additional analysis that he/she may deem necessary, alongside references to research etc.

The report will then be presented to the Review Team to discuss at their next meeting and consider its findings with a particular focus on the Key Lessons Learned. Review team members should agree with the author meaningful recommendations that can be implemented by the relevant agencies.

There will also be the need for the Review Team to consider whether a request needs to be made to an individual agency to ensure appropriate action is taken to make improvements.

6.2 Arrangements will need to be finalised within the Review Team meeting for the 2nd Learning Event.

6.3 Armed with the additional views and contributions from the Review Team, a revised Draft 2 Overview Report will be written.

7. Review – Learning Event 2

7.1 This will be the opportunity for those professionals from the first Learning Event to return to hear from the Independent Safeguarding Lead/Overview Author of the findings and Key Lessons Learned as contained within the Draft 2 Report. This will need to be presented in summary form to the participants, not as a written

document. The group can be asked to consider the Key Lessons Learned and from these identify how they can be transposed into practice on a day to day basis, the likely impact of their implementation, as well as the practicality of achieving them. It will be important however to acknowledge that a number of the lessons to emerge would not fall into the SMART categorisation of a recommendation, and will take much broader strategic developmental approach. For this reason the Review Team may consider it valid to seek additional attendance from key strategic managers to this second Learning Event.

8. Finalising the Process

8.1 The final version of the Overview Report, will be presented to the Review Team for their endorsement and will have finalised from the second Learning Event, the main areas for learning and development that need to take place as a result. A main outcome from this final meeting is to agree how these will be formulated to enable the LSCB to ensure that it obtains maximum learning and development from the process.

8.2 The Report will be sent to involved agencies for factual accuracy checking

8.3 The Report will be presented to the SCR Sub Committee for quality assurance and agreement.

9. Adoption by ESCB

9.1 Presentation of the outcome of the Review including key learning and themes from the case to the ESCB by the Lead Reviewer.

9.2 ESCB to agree their response and actions as a result.

10. Lessons learned and dissemination

10.1 The SCR Sub Committee will develop an overall collated action plan.

10.2 The SCR Sub Committee will agree arrangements for publication in consultation with the Director of Children's Services and ESCB Independent Chair

10.3 SCR Sub-Committee members have responsibility for informing their own agencies of the publication date

10.4 The Report and agreed ESCB media statement will be circulated to SCR Sub Committee and involved agencies 2 weeks before publication and to ESCB 1 week before publication.

10.5 Arrangements will need to be made to ensure that there is feedback to the family about the process and about the likely arrangements for publication.

How the ESCB manage communication and media statements.

The overarching media statement will come from the ESCB Independent Chair and will be approved by ESCB Legal Adviser.

11. Implementation and Monitoring of Action Plans

11, 1 Requests will be sent quarterly to all agencies who have outstanding recommendations requesting an update on the status and progress of implementation. Responses will be collated and presented to the SCR Sub Committee.

11.2 It is expected that SCR Sub Committee members will be responsible for auditing the responses provided by their agency/ies.

11.3 All Action Plans should be completed within one year of the first request for update.

Other Types of Review which may be considered

Partnership Learning Review

If it is decided that a case does not require a full SCR because the criteria in regulation 5(2) are not met the Serious Case Review Sub Committee may recommend to the ESCB Independent Chair that a Partnership Learning Review (PLR) is commissioned if it is agreed that there is potential learning to be achieved.

PLR Process

PLRs will follow the core Model for conducting Serious Case Reviews, steps 1 to 8 and, as in SCRs, will be adapted to suit the details and complexity of each case. Details of methodology will be agreed with the lead reviewer.

What is different about PLRs is that the Report itself is not published and does not have to be sent to the National SCR Panel of Experts.

It is expected that agencies demonstrate the same level of commitment to PLRs as SCRs

Step 9 - Finalising the Process

9.1 The final version of the Overview Report, will be presented to the Review Team for their endorsement and will have finalised from the second Learning Event, the main areas for learning and development that need to take place as a result. A main outcome from this final meeting is to agree how these will be formulated to enable the LSCB to ensure that it obtains maximum learning and development from the process.

9.2 The Report will be sent to involved agencies for factual accuracy checking

9.3 The Report will be presented by the Lead Reviewer to the SCR Sub Committee for quality assurance and agreement.

Step 10. Adoption by ESCB

10.1 Learning themes will be shared with the ESCB by a nominated member of the SCR Sub Committee.

10.2 ESCB to agree their response and actions as a result.

It is expected that actions/learning themes from Partnership Learning Reviews will be published.

These PLRs will be accountable to the Board and the Board will have the same expectation of Partners in contributing to these reviews as in the case of formal SCRs.

Stages of PLR Process

Stage	Actions/Tasks	By whom	By when
	– Appoint Independent Reviewer in line with agreed ESCB Procedure		
1. Scoping Meeting	– Establish time period for the Review and broad themes for Terms for Reference – Discuss with Police re family contact before contact is made by agencies completing chronology – Set timetable for Review (to include meetings with family; Practitioners; Managers) – SCR Sub Committee to identify the agencies required to take part in order for them to nominate the right Review Team members. It is recommended that Review Team members are not the same representatives who sit on the SCR Sub Committee – Agree the pseudonym that will be used for the Review	SCR Sub Committee	Week 3
	- If required, letter sent to family members requesting disclosure of medical records - Involved agencies' Chief Officers requested to: (a) identify chronology authors and provide contact details. (b) submit the following:- (i) chronology on ChronoLator template supplied; (ii)summary of identified themes and potential learning; (iii)action plan to address any learning points. (c) identify practitioners with direct involvement in the case and provide contact details (d) ensure commitment to enable chronology authors and practitioners to fully participate in the process	ESCB Support Team; Lead Reviewer	Week 5

2. Information collection and collation	- Review chronologies and summary comments	Independent Lead/Overview Author; Review Team; Chronology Authors; ESCB Support Team	Week 8
3. Establishing Key Themes for Analysis	- Finalise Terms of Reference - Develop and agree Key Themes for Analysis - Agree when and how family will be involved - Letter sent to families inviting meeting with ESCB Board Manager and Lead Reviewer	Review Team; Independent Lead/Overview Author; ESCB Support Team;	Week 8
4. Preparation for Learning Event	- Establish the structure and expected outcomes from the day - Composite chronology to be sent to all Learning Event participants with Guidance for Practitioners document - If further information is required Individual Management Reviews may be requested	ESCB Support Team	Week 11
	- Ensure appropriate participation of practitioners and first line managers - Agencies to brief practitioners and ensure support in place both before and following the Learning Event	Review team; Involved Agencies	
5. Learning Event	– Agree the facts of the case – Consider the child's lived experience – Undertake the work on the Key Themes – Identify Key Lessons Learned	Practitioners and Line Managers; Independent Lead/Overview Author; ESCB Support Team	Week 12
Overview Report – Draft 1 completed	By Independent Lead/Overview Author		Week 15
6. Meeting 5 Discuss Overview Report	– Consider the analysis and findings in the Overview Report – Are particular actions required for individual agencies? – Agree the main lessons learned from the Learning Event and confirm the Key Learning Outcomes	Independent Lead/Overview Author; Review Team; ESCB Support Team	Week 16
Overview Report – Draft 2 completed	By Independent Lead/Overview Author		Week 18

7. Meeting 6 Learning Event Practitioners feedback	– Findings from Overview Report presented to practitioners and operational managers for comment and further development as necessary.	Practitioners and Line Managers; Independent Lead/Overview Author; ESCB Support Team	Week 20
8. Meeting 7 Finalising the Report	– Final agreement re the Overview Report – Overall findings to be developed into priority areas for Learning and Development for attention by the LSCB – Report to be sent to involved agencies for factual accuracy checking	Independent Lead/Overview Author; Review Team; ESCB Support Team	Week 22
9.Presentation to SCR Sub Committee	- Report presented to SCR Sub Committee for quality assurance and agreement - Learning themes shared with the ESCB for agreement of their response and actions	Independent Lead/Overview Author SCR Sub Committee	Week 24
10. Lessons Learned and dissemination	- Feedback to family - Development of overall collated Action Plan - Dissemination of learning - Publication of key themes	SCR Sub Committee	Week 26

Partnership Case Audit – Commissioned by the SCR Sub Committee

A Partnership Case Audit is a multi-agency meeting attended by Managers and Practitioners from all services involved with children, young people and their families. The purpose is to reflect and learn from the way agencies have worked with Children in Need; children and young people who are subject of Child Protection Plans; or children and young people who are in care.

The length of a Partnership Case Audit can vary from 1 ½ hours to a morning. They are chaired by the Professional Standards & Audit Unit.

The results of the meeting are then taken into account by the ESCB in training and service development.

Single Agency Review

Review undertaken by one agency. The resulting Report will be provided to the Board together with an Action Plan for implementation of any learning arising from the review.

APPENDIX 1

Serious Case Review Referral Guidelines for Decision Making

1.

Incident leading to referral

The referral must clearly state why - in line with statutory guidance - a review is thought to be necessary and that the referral is fully supported by the agency concerned.

NB: A short period of reflection is advised before submitting a referral to ensure that it is appropriate.

2. (Timescale 3 working days)

ESCB Manager and the Director/Lead for Safeguarding to undertake initial review and circulate to SCR Sub Committee for comment

Forward Referral to ESCB Independent Chair for information

Note: It may be necessary to gather additional information before the referral/documents are sent to SCR Sub Committee members and this will (appropriately) lead to a longer process. All cases will be referred/notified to the SCR Sub Committee.

3.(Timescale 7 days)

Comments collated by ESCB

Advise Board Independent Chair who will agree whether appropriate for SCR Consideration Panel

NB: Consideration Panel will be convened if SCR is warranted by a majority of SCR Sub Committee members

3(i) **If Yes:**

- **All agencies requested to provide written information held on family**
- **Proceed to consideration panel**

(Timescale – 14 days)

3(ii) **If No:**

- **Letter to Referrer with full explanation of reason(s)**
- **Confirmation to SCR Sub Committee**

4. *(Timescale – 28 days)*

Convene Consideration Panel and appoint Panel Chair, who should be independent of the services directly concerned with the case

Collated multi-agency information will be shared before the meeting

5.

At the consideration meeting the Panel Chair will make clear the purpose of the meeting and ensure that an overview of the case is outlined to all Panel Members based on the information available at that time

6.

The Board's legal adviser will remind Panel Members of the options available to them in considering the circumstances of the case, based on national guidelines and may comment on how they are likely to apply to the case

7.

Panel Chair will require all agencies present to give information known to them about the case and those directly involved. The Panel Chair will seek to ensure that information is clear and unambiguous.

Panel Chair will ensure that key information is carefully logged for future reference

8.

Panel Chair will ensure that the information given by agencies is discussed, questioned where necessary, and clearly understood by the Panel members

9.

Based on the information available related to the incident and the case, the Panel Chair will ask Members of the Sub Committee to explain whether or not they consider that learning may arise from further consideration of the case and whether it should be subject to review - clearly giving a rationale in support of their view (which must be recorded)

Members will be asked to vote based on the following:-

- **(i) The rationale for their view of whether the criteria set out in WT for review are met (Appendix i)**
- **(ii) Proportionality – the type of review undertaken and the learning expected based on the principles set out in WT (Appendix ii)**

The rationale referred to here will be based on agencies' consideration of the circumstances of the case and ***NOT*** *concerns about reviewing processes*

10.

In the event that the Panel considers that further learning could be derived it will then consider the nature of the review that may be appropriate, i.e. SCR or alternate review, also taking into account the advice of the Board's legal adviser. The Panel should also comment on any key issues it believes to be essential in setting out terms of reference for the review.

It is important that the Panel separate consideration of the need for review from the actual review process given that they are two entirely different considerations

11. *(Timescale – 7 days)*

Panel Chair will promptly write to Independent Chair confirming the Panel's recommendation regarding the need for SCR or other review. This letter will make clear the key considerations and rationale of the Panel in reaching its conclusion and highlight any significant areas of disagreement if necessary. This recommendation must be clear and unambiguous to the Chair stating the reasoning behind the decision.

12. *(Timescale – 14 days)*

Independent Chair will promptly consider the recommendations of the Panel and seek clarification or additional information, if considered necessary. It should be clear that the Independent Chair will not automatically accept recommendations from the Panel and will reserve the right to challenge if considered necessary or appropriate. The basis of any challenge from the Independent Chair will be made clear

The options open to the Independent Chair at this point are to accept or reject the recommendations of the Panel or to defer a decision pending receipt of further information. The Independent Chair will reserve the right to review this decision in light of any further information which may become available

13.

The Independent Chair will make a decision and confirm in writing to the Panel Chair and the Chair of the standing SCR Sub Committee.

14.

If SCR or other review to be commissioned the Independent Chair will request that a review panel be convened and a Lead Reviewer be appointed.

15.

Terms of reference and methodology to be discussed and agreed with the Lead Reviewer by the ESCB Manager/Lead for Safeguarding and then signed off by the Panel taking into account key issues arising from the consideration panel discussions

The terms of reference will need to make clear explicitly which organisations/agencies are expected to co-operate with the review and also the basis upon which they are required to contribute information to the review process

Appendix i

Working Together 2015

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5 (1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned

(2) For the purposes of paragraph (1) (e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either - (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Chapter 4, Paragraphs 18 - 20

18. Cases which meet one of the criteria (i.e. regulation 5(2)(a) and (b)(i) or 5(2)(a) and (b)(ii) **must always** trigger an SCR. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide. Where a case is being considered under regulation 5(2)(b)(ii), unless there is definitive evidence that there are no concerns about inter-agency working, the LSCB **must** commission an SCR.

19. In addition, even if one of the criteria is not met, an SCR **should always** be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or secure children's home. The same applies where a child dies who was detained under the Mental Health Act 1983 or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.

20. The final decision on whether to conduct an SCR rests with the LSCB Chair. LSCBs should consider conducting reviews on cases which do not meet the SCR criteria. If an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB **may** still decide to commission an SCR or they may choose to commission an alternative form of case review. The LSCB Chair should be confident that such a review will thoroughly, independently and openly investigate the issues. The LSCB will also want to review instances of good practice and consider how these can be shared and embedded. The LSCB should oversee implementation of actions resulting from these reviews and reflect on progress in its annual report.

Appendix ii

Working Together 2015

Chapter 4, paragraph 10

Principles for learning and improvement

The following principles should be applied by LSCBs and their partner organisations to all reviews:-

- There should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to daw on what works and promote good practice;
- The approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;
- 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;
- 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. This is important for ensuring that the child is at the centre of the process
- Final reports of SCRS **must be published**, including the LSCB's response to the review findings, in order to achieve **transparency**. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections; and
- Improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

APPENDIX 2

Possible Agenda for a Learning Event

1. ***Introductions***
2. ***Outline of the Process – Structure of the Day***
3. ***Brief Overview of the Case***
4. ***Factual Information*** *- The key facts and events in respect of the case will be presented.*
    - *group work to share, agree/change and discuss the factual details of what happened in this case*
5. ***Feedback from Groups***
6. ***Consideration of the Child's Lived Experience***
7. ***Analysis*** *– Into multi-agency groups to consider the Key Themes for Analysis so far identified via the review of professional practice by the Review Team. (These will be presented on the day). The task of each group will be to use their direct experience of the case to consider:*
    - ***How significant was this particular theme in the case****? –* ***Were there particular events or responses to the family which were key in this respect?***
    - ***Were there any challenges or issues about how this theme was able to be addressed in the case****?*
    - ***What was the context of the professional interventions at the time*** *– e.g.; organisational issues, workload, support systems*
    - ***Is there any additional theme that should be addressed***
8. ***Feedback from groups***
9. ***Learning Themes***
    - *Into multi-agency groups – each identify key learning themes for professional practice that can be identified from the review of this case*
    - *How can these be translated into practice and by whom?*
10. ***Agree Learning Themes***
11. ***Review and Close***

Appendix 3

REFERRAL FORM
FOR CONSIDERATION OF SERIOUS INCIDENT BY SERIOUS CASE REVIEW SUB COMMITTEE

Form to be completed by the referring officer following discussion with line manager or designated child protection professional, where appropriate.

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

Please email the completed form by secure email to:
alexandra.stebbings@essex.gov.uk.cjsm.net

If your email system is insecure, please send password protected to:
alexandra.stebbings@essex.gov.uk

Reference should be made to Chapter 4 *Working Together to Safeguard Children* for further information / explanation. (from page 75)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

Agencies are reminded of the need to secure their files as soon as they become aware that a serious case review might take place.

1. Referrer

Name of referrer	
Agency & Designation	
Email address	
Telephone number	
Name of Senior manager/Officer who has authorised this referral	
Agency & designation	
Email Address	
Telephone Number	

2. Child / Children and Family

Name of Child / Children	
Date/s of Birth	
Date/s of death (if applicable)	
Date/s of critical incident	
Home address/es	

Ethnic origin/s	
Subject to a Child Protection Plan?	YES/NO
Whereabouts at time of critical incident	
Carer/s at time of critical incident	

Family Composition/Significant Others:

Name	Relationship to child	DoB	Address	Legal Status and/or current criminal proceedings	Ethnic Origin	Is/was subject of a CPP

Are there other children / siblings in the home or other residence who require safeguarding? ***If yes, please specify in the box below the arrangements that have been put in place in respect of these children.***

3. **Type of Review to be considered**

Serious Case Review ☐

Other type of Review (if does not meet SCR threshold) ☐

4. Other agencies involved:

Name	Agency	Contact Details	Are they still involved?

5. Reason for referral:

Where the answer is yes to any of these questions please provide further information in the boxes below

a)	Does this case involve the death of a child, including death by suspected suicide **and** abuse or neglect is known or suspected to be a factor. This should include situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse.	Yes/No

b)	Does this case involve the death of a child in custody, either in police custody, on remand or following sentencing, in a Young Offender Institution (YOI), a Secure Training Centre (STC) or secure children's homes, or where the child was detained under the mental health Act 2005.	Yes/No

c)	Does this case involve a potentially life threatening injury or serious and permanent impairment of physical and/or mental health and development (through abuse or neglect)	Yes/No

d)	Does this case involve serious sexual abuse	Yes/No

e)	Was the parent murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004?	Yes/No

f)	Has a child been seriously harmed following a violent assault perpetrated by another child or an adult	Yes/No

g)	Does this case give rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children? If yes, use box below	Yes/No

If there are concerns about inter-agency working in this case please specify here what these concerns are:

Please provide summary of incident here

5. Chronology of key dates

Date (& time where appropriate)	Event

6. Date of Referral

7. Signed (by referrer)

APPENDIX 4

(Details of Time, venue, etc)

Guidance for Practitioners

Dear Colleagues

Thank you for participating in this Partnership Learning Review Event.

The focus of this day is on learning and particularly in understanding why things happened or did not happen and making improvements to practice.

We understand that you may feel uncertain or anxious but this is an opportunity for you to help us understand what needs to change and what support might be needed in the future. To do this I will ensure that the event is respectful and supportive, there is no intention to blame anyone, we need to learn together. If you need any clarification about the event please feel free to contact Janet Levett at the ESCB by email at janet.levett@essex.gov.uk or by telephone on 0333 013 9172 who can also put you in touch with me.

You may bring your line manager or organisation safeguarding lead if you feel this would be helpful.

I look forward to working with you

Lead reviewer and Independent Overview Author

The purpose of the PLR event will be:

- For front line practitioners and operational managers, who were or are involved in the case, to participate in the inter agency review of this case following a systems methodology.
- To discuss and agree the factual information compiled about the family in terms of incidents and professional interventions, and to gain agreement or additions/changes to these.
- To work alongside the Review Team to undertake analysis of the professional practice from the key themes which have emerged in respect of the case.
- To assist the Independent Overview Author in gathering information and understanding to enable her to compile the Overview Report.
- To identify the key learning themes from the analysis and:

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

Comments made on the day will not be attributed to individuals. Any themes and comments will be anonymised in the final report.

The Essex Safeguarding Children Board is trying to support practitioners in assisting with these reviews and as this is a new process we would appreciate your comments on the process after the PLR Event as your feedback is important to us.