NSCB Case Review and Learning Framework

1. Purpose

Newham Safeguarding Children Board is committed to ensuring partners learn from practice. Working Together 2013 requires Local Safeguarding Children Boards (LSCB) to put in place a framework to ensure that the Board and their partners are engaged in purposeful and transparent activity to learn from and improve on local practice.

There is a statutory requirement on LSCBs to undertake Child Death Reviews and Serious Case Reviews (SCRs) in certain circumstances. In addition to these statutory reviews, Working Together encourages LSCBs to undertake a wider range of case reviews in order to provide useful insights into the way organisations are working together to safeguarding and promote the welfare of children. This document sets out how this will be undertaken in Newham.

The process of undertaking Child Death Reviews will interface with this framework but is separate to it. Details of this process, including how to refer a Child Death can be found on the NSCB Website.

2. Our Principles of learning from practice

(Taken from Working Together 2013)

The NSCB will:

- Create a culture of continuous learning and improvement to safeguard and promote the welfare of children, identifying opportunities to draw on what works and to promote good practice.

- Take a proportionate approach to reviews that are determined by the scale and level of complexity of the issues being examined.

- Look at what happened in a case, and why, and what action will be taken to learn from the review findings.

- Fully involve professionals and invite them to contribute their perspectives without fear of being blamed for actions they took in good faith.

- Invite families to contribute to reviews and manage their involvement and expectations in an appropriate and sensitive manner.

- Publish final reports of SCRs and the LSCB response to review findings, in order to achieve transparency and set out in the Annual report how the impact of SCRs and other reviews are being used to improve services to children and families and reduce the incidence of deaths or serious harm to children.

- Cascade and embed the learning from SCRs and other case reviews at an operational and strategic level across the partnership and regularly monitor and impact of these lessons in improving outcomes for children.

Our Approach to conducting SCRs and other case reviews will:

- Recognise the complex circumstances in which professionals work together to safeguard children.

- Seek to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.

- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight

- Be transparent about the way data is collected and analysed

- Make use of relevant research and case evidence to inform findings.

3. Governance Arrangements

The sub-groups listed below are accountable to the Executive Board of the Newham Safeguarding Children's Board.

The **Child Death Overview Panel (CDOP)** is responsible for:

- Ensuring that all child deaths in Newham are reviewed in accordance with Chapter 5 of Working Together, 2013.

- Ensuring learning is identified and acted upon.

- Producing an annual overview report to the NSCB.

The **Serious Case Review (SCR)** sub-group of the NSCB is responsible for:

- Reviewing all serious incidents in accordance with chapter 4 of Working Together 2013 to determine if a serious or other case review is indicated and to commission case reviews, where required.

- Commissioning learning reviews in relation to cases which may not meet the threshold for a serious case review but which may still have learning implications for the partnership.

- Scrutinising the implementation of action plans arising from reviews to ensure that actions are implemented, practice is improved as identified and any exceptions are reported to the Executive Board.

- Maintaining an overview of the key themes in recommendations and ensure that agencies are disseminating lessons from serious and other learning reviews, in conjunction with the **Training sub-group.**

The **Training sub-group** is responsible for:

- Ensuring that lessons from SCRs lead to improvements in policy and practice for children, young people and their families.

- Arranging briefing sessions for staff to share the lessons learnt from serious case reviews and other learning reviews

The **Performance and Quality Assurance** sub-group is responsible for:

- Developing and overseeing a programme of multi-agency quality assurance activity.

- Providing scrutiny and challenge to NSCB partner agencies in regard to their statutory safeguarding arrangements to drive improvement

- Quality assuring the progress of SCR action plans including testing impact.

The **Business Manager** for the NSCB is responsible for:

- The effective co-ordination and delivery of SCR and case review activity by the sub-groups.

- Tracking the completion and measuring the impact of related improvement plans.

- Publicising the lessons learnt and how are being used to improve practice and outcomes for children in the NSCB Annual report and through the NSCB newsletter.

4. Criteria for Serious Case and Learning Reviews

The Newham Safeguarding Children's Board (NSCB) case review and learning framework covers the following areas:

- **Serious Case Reviews:** cases meeting the statutory threshold for review as set out in Working Together 2013. This includes every case where abuse or neglect is known or suspected and **either**

  A child dies; or
  A child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

  In addition, even if one of these criteria is not met, a Serious Case Review **should always** be carried when any of the following circumstances arise:

  - Death caused by serious youth violence
  - The suicide of a young person
  - Death of a young person in custody, on remand or following sentencing, in a Young Offenders Institution, in a secure training centre or a secure children's home
  - Death of a child detained under the Mental Capacity Act 2005
  - Children affected by a Domestic Homicide

- **Learning Reviews of child protection incidents:** cases outside of the threshold for a serious case review. This will include cases where:

  - There has been a "near miss".

- There appears to be learning for how agencies could work together better to safeguard children in the future.
- The case raises issues that require the development of policy or practice guidance.
- Examples of good practice should also be reviewed and shared.

5. How to refer a case for review

Identification of Cases

Each partner agency should have in place their own **internal arrangements** for **identifying** and **notifying** their LSCB lead officer of cases where there has been a serious incident involving a child which may meet the threshold for either a SCR or learning review.

For example, the Local Authority has defined a serious incident as one which involves a child or young person in any of the following:

- Death or serious injury where abuse/neglect is known or suspected
- murder, attempted murder or manslaughter
- rape
- torture
- kidnapping
- false imprisonment
- firearms offences
- a knife crime or serious assault that has resulted in hospitalisation

The local authority has arrangements in place to ensure that all potentially serious incidents are notified to the Director of CYPS within two hours of the incident occurring.

The **NSCB Decision making process** is set out in a flow chart in Appendix 1.

Referral

Where an agency identifies a case which they consider meets the criteria for a serious case or other learning review, they should alert the identified lead within their agency who will determine whether the case should be referred to the NSCB Business Manager using part 1 of the form in Appendix 2. All referrals should be authorised by an agreed senior manager or clinical lead within that agency.

Referral response

The NSCB Business Manager will notify all SCR sub-group members of the details of the case in order that initial information gathering about their agency's involvement in the case can be undertaken using part 2 of the form in Appendix 2.

This information will be reviewed by the Chair of the SCR sub-group who will determine, with the advice of the NSCB Business Manager, whether an SCR or learning review appears to be indicated. If this is the case the NSCB Manager will convene an SCR sub-group within 10 working days of the notification. The sub-group will consider the information and make a recommendation to the NSCB Chair about the type of review required.

Decision making

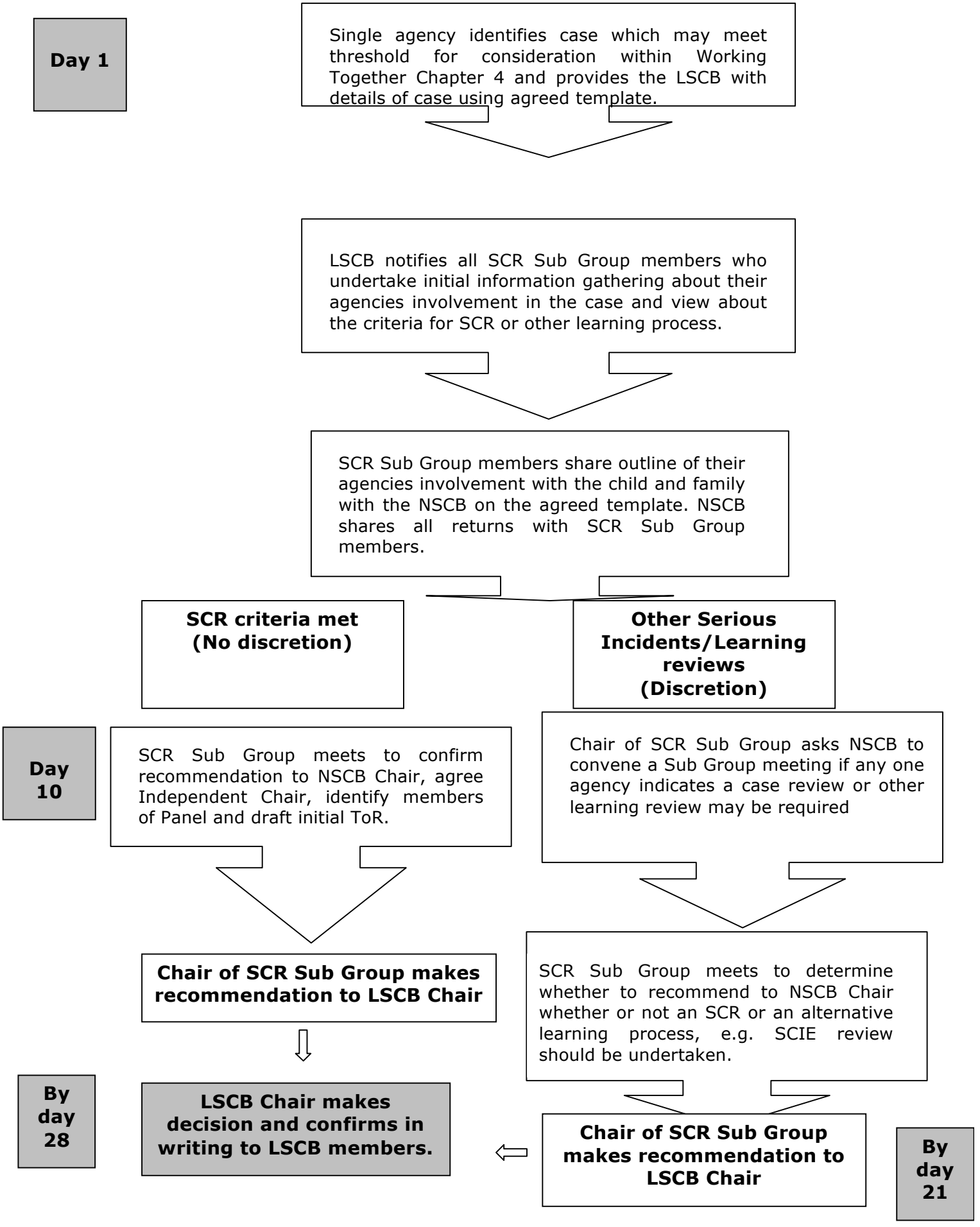
The SCR Chair will discuss the recommendation with the Independent Chair of the NSCB who will make the final decision regarding an SCR or other learning review within 10 working days of the sub-group being convened.

The NSCB should let Ofsted and the national panel of independent experts know their decision.

Challenging a Decision

If any agency disagrees with the decision taken by the SCR Sub-group they should put their concerns in writing, as soon as possible, and discuss this with the Independent Chair of the NSCB whose ultimate decision is final.

Appendix1: NSCB SCR Decision-making



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LOCAL SAFEGUARDING CHILDREN BOARD

Appendix 2: Notification of a Potential Serious Case Review or Learning Review

PART ONE – to be completed by the referring agency

SCR Group	**Details of Agency Involvement with Child/Young Person**

Name of Agency:

Name of team/lead professional: (if applicable)

Lead Officer Name & Contact Details:

Senior Manager or Clinician authorising this referral:

Full Name of Child/Young Person:

Date of birth:

Ethnicity:

Language spoken:

Religion:

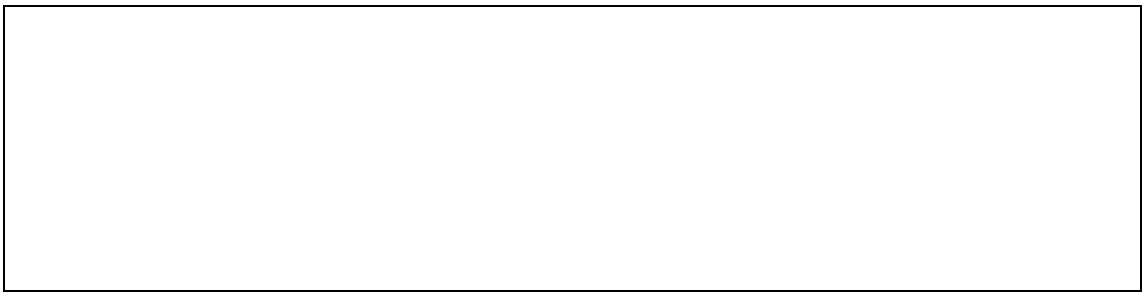
Disability and/or additional needs:

Basic Family Details: (including parents/carers, siblings and other key individuals. Highlight who was caring for the young person and who hold parental responsibility)

Home Address:

Details of any previous home addresses:

Reason(s) for referring this case to the Serious Case Review sub-group: (with reference to the criteria for Serious Case and Learning Reviews)



PART TWO – Initial information to be completed by partner agencies in advance of SCR Sub-group meeting

SCR Group	Details of Agency Involvement with Child/Young Person

Name of Agency:

Name of team/lead professional: (if applicable)

Lead Officer Name & Contact Details:

Full Name of Child/Young Person:

Date of birth:

Ethnicity:

Language spoken:

Religion:

Disability and/or additional needs:

Basic Family Details: (including parents/carers, siblings and other key individuals. Highlight who was caring for the young person and who hold parental responsibility)

Home Address:

Details of any previous home addresses:

Summary of this agency's involvement with the young person and family: (Include details of any assessments, plans, services and statutory orders with start and end dates of agency involvement and outcomes)

Date and circumstances when the child/young person was last seen by your agency:

Summary of the risks and strengths in relation to the young person and the intervention provided by your agency

Completed by:

Title:

Date:

This form should be securely returned to the NSCB Business Manager at: lscb@newham@gov.uk