Serious Case Review Sub Group
Terms of Reference

Mandate

The Local Safeguarding Children Board is responsible under regulation 5 of the LSCB regulations 2005 for undertaking a Serious Case Review (SCR) where the criteria is met. The SCR standing Sub group has the mandate for considering all cases potentially meeting the criteria for SCR against regulation 5 of the LSCB regulations 2006.

5(1)(e) undertaking reviews of Serious Cases and advising the authority and the 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, the Board partners or other relevant persons have worked together to safeguard the child.

Cases that 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 a 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.

Core Objectives

- To provide assurance to the LSCB that recommendations arising from SCRs have been actioned and learning from lessons have been clearly communicated and disseminated to all partner agencies and frontline staff.
- That all lessons learned are clearly aligned to the Learning and Improvement Framework and to the Training and Workforce Development Strategy.
- That recommendations and lessons learned inform and underpin the work of the Quality Assurance Sub Group and influence and drive audit and Quality Assurance activities across the partnership.
- As a consequence of the identification and implementation of lessons, to evidence interagency learning as a result of SCR actions plans

Membership

The membership of the Serious Case Review Group consists of key managers from partner organisations. The chair of the SCR sub group sits on the Operational Board.

Sarah Glossop	Designated Nurse, Safeguarding	NELCCG
Paul Cordy	Director Children's Services	North East Lincolnshire Council
Helen Willis	LSCB Coordinator	LSCB
Dr Bukar Wobi	Designated Paediatrician	Clinical Commissioning Group
Rupert Sellers	Senior Probation Officer	National Probation Service
Becky Bailey	Interchange Manager	Community Rehabilitation Company
Megan Dennison	Head of Safeguarding (Principal Child & Family Social Worker)	North East Lincolnshire Council
Marcia Pathak	Lead GP for Safeguarding	
Bob Ross	Head of Children's Public Health Provision	North East Lincolnshire Council

Sue Proudlove	Children's Service Manager	NSPCC
Carol Ellwood	Detective Chief Inspector	Humberside Police
Craig Ferris	Head of safeguarding Children and Adults	Clinical Commissioning Group
Julie Wilburn	Designated Nurse, Safeguarding	NELCCG

Meeting Arrangements

The SCR Sub Group is chaired by the Director of Children's Services and will be held on a quarterly basis. Special meetings of the group will be help to consider referrals to the process.

Responsibilities

The Serious Case Review Sub Group will provide an Annual Report to the Leadership Board on the Learning from SCRs. Responsibilities include:

- Consider whether incidents notified to the SCR Sub Group meet the criteria for SCR
- Make recommendations to the LSCB chair in respect of whether the criteria for SCR is met
- Notify Ofsted and the National SCR Panel of the LSCB chairs decision.
- Consider whether a review should be undertaken where the criteria for SCR has not been met but where:
  - Single agency audits or reviews of cases identify significant practice issues within the service's own safeguarding systems, processes or procedures
  - Complex cases that raise concerns and have implications for more than one agency or service with regard to: Referral, assessment, planning, intervention, decision-making and information sharing
  - Cases in which good or excellent practice has been identified which, indicate there would be benefit from a review or in depth scrutiny of factors that would promote good practice and from which agencies could learn from
  - Cases that have been audited via the multi-agency audit framework and it is felt the case meets any other criteria above and would benefit from review
  - Complex or 'stuck cases' with which a practitioners or managers are struggling to find a way forward and would benefit from an in depth analysis of factors preventing progress or posing a risk
- On behalf of the LSCB overseeing the management of SCRs including:
  - Commissioning Independent SCR authors
  - Ensuring the involvement of all relevant agencies and the family
  - Setting up SCR panel
  - Development, management and implementation of SCR action Plans
- Publish SCRs

Activity

- SCRs and other case reviews should be conducted in a way that:
  - 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.
- Review the learning from national SCRs and disseminate learning
- Hold regular practice forums to disseminate learning
- Learning from SCRs informs training and practice development

Outcome and Success Measures

- SCRs lead to learning that informs practice
- SCR actions plan lead to improvement in practice