Serious Case and Domestic Homicide Reviews

Policy, procedure and guidance

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Document control	All printed copies of this document are classified as uncontrolled. A controlled version of the document is available on the intranet.

This document contains:
Policy Broad statements that MUST be followed
Procedure Step by step instructions that MUST be followed
Guidance Recommended practice that SHOULD be followed

1. About this document

This document aims to make clear what employees and volunteers must do when The Children's Society is asked by a Local Safeguarding Children Board (LSCB) to take part in a Serious Case Review (SCR), an Independent Management Review (IMR) or a Domestic Homicide Review (DHR).

It aims to make sure that employees and volunteers understand their part in these reviews, and that their response is safe, consistent and sensitive to those involved.

Further, this document will enable the organisation to make sure that, following a review process, good practice is highlighted and any lessons learnt are widely disseminated as soon as they are known, so that appropriate changes can be made to systems, policies and practice.

Definitions

Child or young person: Anyone who has not yet reached their 18th birthday.

Employees: Anyone employed by The Children's Society, including agency employees and those on secondment or placement (including internships both paid and voluntary).

Volunteers: Anyone volunteering for The Children's Society, regardless of their role, including trustees.

2. Policy

A broad statement that MUST be followed

Serious Case Reviews

2.1 About Serious Case Reviews

A Serious Case Review (SCR) is held when a child has died and abuse or neglect is known, or suspected, to be a factor in the child's death. Or, when a child has been seriously harmed or has died from suspected suicide and there is cause for concern as to the way in which the authority, their LSCB partners, and/or other relevant agencies or persons, have worked together to safeguard the child. SCRs carefully consider the circumstances surrounding the death or any injury that took place prior to the incident.

The prime purpose of an SCR is for agencies and individuals to improve the way they work, both individually and collectively, in a way that makes sure important factors in the case are indentified, that the appropriate action is taken to make improvements, and that the safeguarding and welfare of children is promoted.

2.2 The Children's Society and Serious Case Reviews

Although it is rare, there are times when children and young people who The Children's Society work with suffer serious injury, and in some instances death where there may be concerns about the circumstances of the death and/or multi-agency working within the area. In these circumstances, the LSCB is required by law to commission an SCR.

If one of The Children's Society's services has been involved with a child who has suffered a serious injury or who has died as a result of injury, neglect or suicide, the organisation may be asked to contribute to the review in a number of ways. The Children's Society is committed to full and meaningful cooperation and participation with any such review.

When The Children's Society is directly involved in an SCR, a detailed response must be made regarding lessons learned and steps taken to improve practice. Managers from The Children's Society contributing to an SCR must take the important principles below into consideration.

2.3 Serious Case Review principles

LSCBs can use any learning model for an SCR that is consistent with The Munro Review of Child Protection Final Report: A Child-centred System (as set out in Working Together to Safeguard Children 2015, chapter 4). Managers from The Children's Society who are asked to contribute to an SCR will need to establish what model or approach is being used.

The following principles regarding SCRs are set out in Working Together to Safeguard Children 2015:

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

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

- Seeking to understand practice and the viewpoint of the individuals and organisations involved at the time, rather than using hindsight.

- Transparency about the way data is collected and analysed.

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

Domestic Homicide Reviews

2.4 About domestic abuse and violence

The cross-government definition of domestic abuse and violence is: 'any incident or pattern or incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family/ household members regardless of gender or sexuality'. This can encompass, but is not limited to:

- Psychological abuse
- Physical abuse
- Sexual abuse
- Financial abuse
- Emotional abuse
- Forced marriage

2.5 About Domestic Homicide Reviews

When someone has been killed as a result of domestic abuse (domestic homicide), a review will be carried out. Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims (Amendment) Act 2012.

The purpose of the review is for professionals to understand what happened in each homicide, and to identify what needs to change to reduce the risk of future tragedies. A similar process to an SCR will take place.

2.6 The Children's Society and Domestic Homicide Reviews

Where The Children's Society has had recent direct involvement in a case, it may be invited to contribute to the review process. The Children's Society is committed to full and meaningful cooperation and participation with any such review. Managers from The Children's Society must take into consideration that the purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- How, and within what timescales, the lessons will be acted on, and what is expected to change as a result.

- Apply the lessons to service responses, including changes to guidance and policies.

- Prevent domestic abuse homicides and improve service responses for all domestic abuse victims and their children, through improved intra and inter agency working.

There are some important points to note regarding DHRs:

- DHRs are not inquiries into how the victim died or into who is culpable. That is a matter for coroners and criminal courts, respectively, to determine as appropriate.

- DHRs are not specifically part of any disciplinary enquiry or process. Where information emerges in the course of a DHR indicating that disciplinary action should be initiated, The Children's Society disciplinary procedures should be undertaken separately to the DHR process. Alternatively, some DHRs may be conducted concurrently with, but separate to, disciplinary action.

- The rationale for the review process is to make sure that agencies are responding appropriately to victims of domestic abuse, by offering and implementing appropriate support mechanisms, policies, guidance, resources and interventions, with an aim to avoid future incidents of domestic homicides.

- The review will assess whether agencies have sufficient and robust guidance and policies in place that are understood and adhered to by employees.

3. Procedures

Step by step instructions which MUST be followed

Serious Case Reviews

3.1 Events likely to result in a Serious Case Review

Service managers and area managers must notify the area director, the director of children and young people (CYP) and the safeguarding team **within one working day** if they become aware of either of the following circumstances, which could lead to an SCR:

- A child or young person that The Children's Society has been working with has died and abuse or neglect is known or suspected to be a factor in the child's death.

- A child has been seriously harmed or has died from suspected suicide.

3.2 Independent Management Reviews

When an LSCB becomes aware of circumstances that may lead to an SCR, it can commission what is usually called an Independent Management Review (IMR). The IMR process will be guided by the LSCB. This process usually leads to a request for a report or chronology from the agencies who were, or have been, directly involved with the child, young person or family.

3.3 Responsibilities when responding to an IMR

Any request for a report and/or a chronology will normally come from the chair of the LSCB to the relevant area manager at The Children's Society. Such requests must be brought to the immediate attention of the area director, the director of CYP and the safeguarding team **within one working day**.

The safeguarding team will provide guidance to the area director on the process for securing relevant case files, supervision notes and handwritten notes, as well as other data that may be stored on electronic devices such as iPads and mobile phones. The area director is responsible for ensuring the documents are secured **within one working day** of becoming aware of the SCR. The safeguarding team will retain this data for the duration of the SCR process.

The area director and area manager must take the necessary steps to make sure that employees and volunteers who are, or who have been, directly involved with the child or young person are appropriately supported.

The practice systems manager will make sure that the Mosaic records, and any relevant secondary systems, are locked. Only the people who need access for the purpose of the review should be able to access these records.

It is the responsibility of the safeguarding team to:

- Initially liaise with the LSCB that is commissioning the SCR on all matters related to the information required.

- Work with the director of CYP and area director to identify a suitably qualified and independent CYP manager to participate in the preparation of reports and chronology for the SCR. This manager (who cannot have line management responsibility for the service involved) will then liaise with the LSCB.

- Work alongside the appointed independent CYP manager to support and assist in the process, including collating and submitting information to the LSCB.

- Notify the director of CYP and area director of any immediate concerns about serious failings and the quality of practice in the relevant service.

The Children's Society must also consider whether:

- The relevant Safeguarding Framework policy and guidance, LSCB interagency procedures, and Working Together guidance were followed.

- The case suggests that there is an urgent need to review internal processes in the light of lessons learnt.

- Any other action is needed to improve immediate practice and be disseminated throughout The Children's Society.

The strategic lead for safeguarding will inform the director of CYP of the recommendations, actions and learning that emanate from the IMR process. The director of CYP will inform the risk, audit and compliance committee of the trustee board, and report progress towards embedding such learning through the meetings of the safeguarding group.

3.4 LSCB sub-groups

The IMR report will outline steps for internal learning and improvement, with clear timescales, which will be submitted to the LSCB sub-group.

If The Children's Society is directly involved in the LSCB sub-group, the scope for engaging and commenting on the final report or recommendations is considerably enhanced. Should allocated The Children's Society manager be invited (or already be part of) the LSCB sub-group or SCR team, they will make a contribution as required. The area director will make sure that the manager has the capacity to engage fully with this process, and they will be supported by the strategic lead for safeguarding.

If The Children's Society is not a member of the LSCB sub-group, the relevant area director is responsible for requesting a draft copy of the SCR for comments prior to publication. The safeguarding team will provide guidance and support with this process.

3.5 Learnings from Serious Case Reviews

By the time the SCR report is published, The Children's Society will have put in place all necessary learning. If required, this will include:

- A full ‘Lessons Learned Audit’ at the relevant service, conducted by the safeguarding team. This process will look at all areas identified in the IMR and draft SCR. It will identify where progress has been made and detail any outstanding gaps in learning and practice. The Lessons Learned Audit report will be given to the relevant area director and the director of CYP so that they can take appropriate action.

- The safeguarding team will make sure that lessons learnt and recommendations developed at every stage in the process are incorporated into safeguarding training and relevant briefings. Area managers will be responsible for ensuring that service managers include briefings to their teams in team meetings and individual supervisions.

- The safeguarding team will make sure that the relevant changes to systems, practice, policies and procedures are conveyed to those with the lead responsibility.

- All of the above will be reported to the corporate safeguarding group by the strategic lead for safeguarding.

Any outcomes concerning practice, learnings and their implementation that arise from the SCR will be the joint responsibility of the strategic lead for safeguarding and the director of CYP.

Domestic Homicide Reviews

3.6 Responding to Domestic Homicide Reviews

If a service has been involved with a child or adult who is the subject of a DHR (whether as the victim or the perpetrator of the homicide) The Children’s Society may be contacted to produce a Management Review detailing our involvement with that child or adult for the DHR Panel.

Any requests for The Children’s Society to produce such a report or to participate in a review should come directly to the director of CYP. Should such a request be made directly to a programme, the area manager must bring this to the attention of the area director, the director of CYP and the safeguarding team **within one working day.**

If a request is made, records must be secured **within one working day.** The safeguarding team will provide guidance to the area director (as detailed in section 3.3).

The practice systems manager will make sure that the Mosaic records, and any relevant secondary systems, are locked. Only the people who need access for the purpose of the review should be able to access these records.

It is the responsibility of the strategic lead for safeguarding to:

- Inform the director of CYP of the involvement in the DHR and, where necessary, raise any immediate concerns about the quality of practice in the programme.

- Initially liaise with the safeguarding board that is commissioning the DHR on all matters related to the Terms of Reference of the Management Review.

- Work with the director of CYP and the area director to identify a suitably qualified independent CYP manager to participate, process and/or write The Children's Society's Management Review. This manager cannot be anyone who has line management responsibility for the service involved.

It is the responsibility of the independent CYP manager, with the support of the safeguarding team, to collate and/or oversee the Management Review process and to make sure that the director of CYP is sighted on the report and accompanying action plan. The director of CYP will sign off the report and action plan and make sure it is monitored.

The corporate safeguarding group should be informed of any DHRs and action plans.

3.7 Objectives of a Management Review

Within The Children's Society, the objectives of the Management Review will be to establish whether:

- The Children's Society's guidance and policies (as set out in the Safeguarding Framework) were followed.

- The LSCB's interagency procedures and Working Together 2015 were followed.

- The Local Safeguarding Adults Board's safeguarding procedures were followed.

- The case suggests that there is an urgent need to review guidance and polices in the light of lessons learnt.

- Any other action is needed.

- Any practice learning needs to be disseminated throughout The Children's Society.

The Management Review will require that the following main tasks be carried out by the independent CYP manager, supported by the safeguarding team:

- Identifying and reading file material.

- Interviewing key practitioners and managers.

- Establishing a factual chronology.

- Assessing whether decisions and actions taken in the case were in line with the organisation's guidance and policies.

- Determining what services were provided following the decisions and actions in the case.

- Producing recommendations for action in the light of analysis of the review findings.

3.8 Learnings from a Management Review

Lessons on how The Children's Society works to safeguard children and adults at risk of domestic violence, and to promote their welfare, will be captured in the Management Review. Good practice, and how practice can be improved, will be highlighted. Any implications for ways of working, training, management and supervision, or working in partnership with other agencies and resources will be included in the recommendations from the review.

Any actions to be taken, along with any desired outcomes and how management will detemine whether they have been achieved, will be included in the recommendations.

By the time the DHR report is published, The Children's Society will have put in place all necessary learning. If required, this will include:

- A full Lessons Learned Audit at the relevant service, conducted by the safeguarding team. This process will look at all areas identified in the DHR. It will identify where progress has been made, and detail any outstanding gaps in learning and practice. The Lessons Learned Audit report will be given to the relevant area director and the director of CYP so that they can take appropriate action.

- The safeguarding team will make sure that recommendations developed at every stage in the process will be incorporated into safeguarding training and relevant briefings. Area managers will be responsible for ensuring that service managers include briefings to their teams in team meetings and individual supervisions.

- The safeguarding team will make sure that the relevant changes to systems, practice, policies and procedures are conveyed to those with the lead responsibility.

- All of the above will be reported to the corporate safeguarding group by the strategic lead for safeguarding.

A report concerning any involvement of The Children's Society in a DHR will be made to the risk, audit and compliance committee. The director of CYP has responsibility for presenting the report to the committee.

Any outcomes arising from the Management Review concerning practice, learnings and their implementation will be the joint responsibility of the strategic lead for safeguarding and the director of CYP.

4. Guidance

Recommended practice that SHOULD be followed

Guidance to be added in a six-month review of this policy and procedure.

5. Relevant Resources

- Local Safeguarding Children Boards follow statutory guidance for conducting Serious Case Reviews.

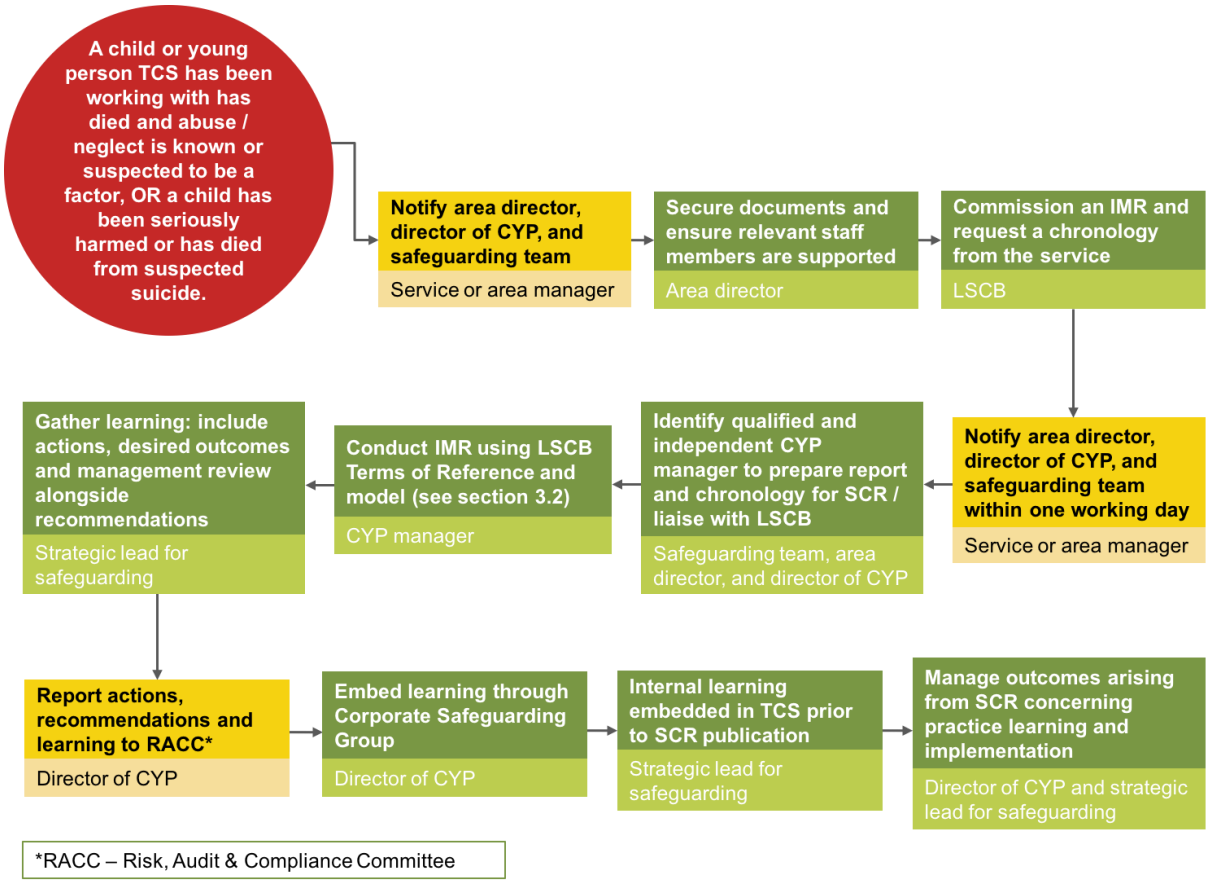
- The NSPCC, working with The Association of Independent Chairs of LSCBs, has created the National Case Review Repository to make it easier to access and share learning at a local, regional and national level:

- A full summary of Serious Case Reviews published in 2016 year can be found here.

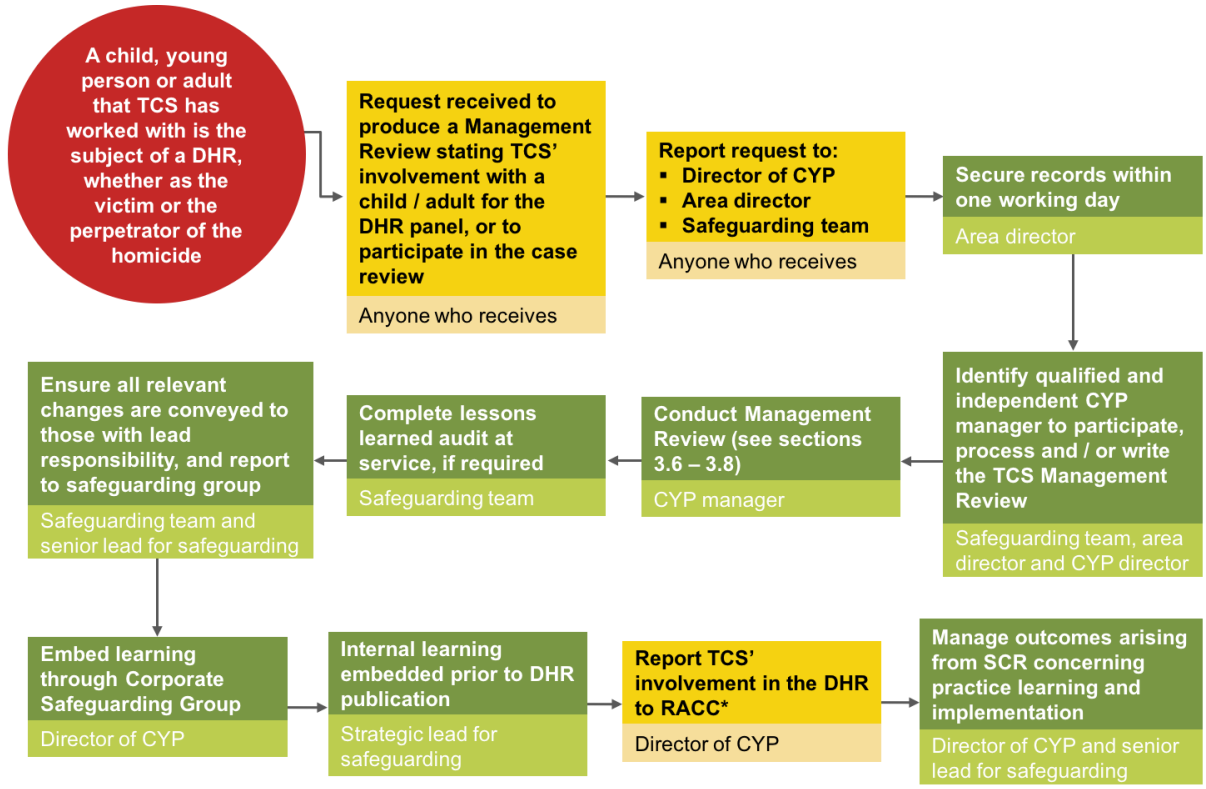
- Multi-agency statutory guidance for the conduct of Domestic Homicide Reviews.

6. Annexes

6.1 Serious Case Review process



6.2 Domestic Homicide Review process



The safeguarding team ensure that lessons learned and recommendations developed are incorporated into safeguarding training and relevant briefings. Areas managers ensure that service managers include briefings to their teams in team meetings and individual supervisions.
*RACC – Risk, Audit and Compliance Committee