

## Re-consideration of Serious Case Review

LSCB: Bradford

Initials of Child HD

Date of Death 16/07/06

Date Original SCR submitted to Ofsted 22/11/07

Date Evaluation letter sent 04/09/08

Date report submitted to Secretary of State 27/02/09

## **1. Introduction**

This review is being conducted following a letter dated 16 December 2008 from the Minister of State, Beverley Hughes, to Chairs of Local Safeguarding Children's Boards and Directors of Children's Services requiring them to review all serious case reviews judged by Ofsted to be "inadequate" by the end of February 2009.

HD was born on 4 June 2004 and died on 16 July 2006 from cardiac and respiratory arrest. Toxicology results confirmed the presence of methadone and non prescription drugs in his body which had been ingested over a long period of time.

His mother SR had had two previous children removed because of the danger posed to them by her (then) partner. HD was placed on the child protection register from birth and remained on that register throughout his life. SR has a long history of drug abuse and was involved with many drugs agencies throughout HD's life.

Bradford Safeguarding Children Board (BSCB) commissioned a serious case review (SCR) into his death in August 2006. The report was submitted to Ofsted on 22 November 2007 with the executive summary being sent on 7 July 2008. On 4 September 2008 Ofsted deemed the SCR to be "inadequate".

This report will address the SCR process issues that Ofsted found to be inadequate and identify the lessons to be learned. The Panel is also re-examining the case in a further report to assist BSCB in working with drug-using parents. BSCB will also build on this report to improve its future SCRs.

## **2. Arrangements for review**

An independent overview author, Mr. Barry Raynes, was appointed on 17 December 2008. He is the executive director of Reconstruct, a company dedicated to improving services for children. He has worked in children's social care for 30 years. He has written child protection procedures for over 30 Authorities in England, Wales and Scotland in the last two years. He has conducted a number of SCRs as well as overseeing all those completed by Reconstruct. He is currently researching a PhD in communication in child protection. Mr. Raynes has no previous or current case work or managerial responsibility or affiliation with Bradford.

An independent chair for the new review panel, Mr. Paul Sharkey, was appointed on 5 January 2009. Mr. Sharkey is Calderdale's safeguarding manager. He is responsible for the support team to Calderdale's Safeguarding Children Board, the Independent Reviewing Officer Team, the child protection co-ordinator team, the co-ordination for the protection of children from child sexual exploitation, and the safeguarding information database. He has been involved in child protection work since 1984 and has considerable involvement in SCRs. He has a Masters degree in Public Administration and an MA in Childcare law and practice. Mr. Sharkey has no previous or current case work or managerial responsibility or affiliation with Bradford.

An overview Panel was convened consisting of

Paul Sharkey	Manager, Calderdale LSCB - Independent Chair
Liz Barry	Joint Commissioner (SMS) Bradford & Airedale Teaching Primary Care Trust (tPCT)
Richard Bates	Assistant Director – Children's Social Care, Bradford Metropolitan District Council (BMDC)
Supt Steve Cotter	West Yorkshire Police
Barbara Cox	Designated Nurse for Safeguarding, Bradford & Airedale tPCT
Paul Hill	Manager, BSCB
Marion Moraghan	Social Services Law Team

None of the members of this Panel were members of the original Panel, or have had any involvement with HD.

The following terms of reference (page 7 of this report) were agreed on 29 January 2009. During the process of this review it became apparent that these terms of reference were too comprehensive but it was decided by the Panel on 24 February 2009 that they would remain in place to assist with the writing of the subsequent report on lessons learned.

The Panel met on 2, 6, 13, 18 and 24 February 2009. Each Agency that had previously submitted an "inadequate" individual management review (IMR) was requested to submit a new review and these were all completed by 30 January 2009. They were:

1. Bradford Children's Social Care
2. Bradford and Airedale Primary Care Trust
3. Ripple Day Treatment Programme

4. Caleb
5. The Fair Weather Project
6. The Home Key Project

The Panel also requested IMRs from Bradford Safeguarding and Reviewing Unit and the Nursery that HD attended.

The Panel considered:

1. how process "issues" which contributed to the Ofsted "inadequate" judgment have been acted on
2. whether it was solely the process which led to an inadequate judgment or whether the actual findings and conclusions of the SCR needed revisiting
3. whether the Panel had confidence in the integrity of the SCR's conclusions
4. whether there have been tangible improvements made through the implementation of the action plan and recommendations.

The Panel concluded that, while many of the problems were caused by a poor process, it was not solely the process which led to an inadequate judgement as the original SCR was lacking in analysis and rigour. As the Panel did not have confidence in the integrity of the original SCR's conclusions it requested that Bradford's Safeguarding Manager produce a lessons learned report for consideration by BSCB. This allows time for the mother SR to become involved in the process and have contact while ensuring that the process of writing this review is not compromised. The Safeguarding Manager will complete his report by 15 April 2009. Despite the flawed findings and conclusions of the original review the Panel were pleased to note that many improvements had been put in place already as a result of this case.

The Panel therefore

1. reviewed all the original IMRs and those recently commissioned,
2. requested the independent author to reconsider conclusions and recommendations,
3. critically assessed Bradford's SCR procedures,
4. identified what improvements have been put into place since the original SCR was completed,
5. used these investigations to inform the lessons learned report.

The Panel agreed that the process issues this report will concentrate on are:

- 1) what guides exist for the following?
  - a) understanding the process of SCRs
  - b) terms of reference
  - c) family involvement
  - d) independence
  - e) chronologies
  - f) individual management reviews
  - g) lessons learned reports
  - h) action plans.
- 2) are they compliant with present Ofsted expectations and emerging good practice?
- 3) do they advise IMR authors about quality issues?

Additionally the concerns expressed by Ofsted in their letter of 4 September 2008 would be addressed. These were:

- 1) The terms of reference were inadequate
- 2) There was considerable delay
- 3) There was a lack of independence
- 4) There was poor involvement of family members
- 5) The IMRs were not systematically analysed
- 6) Dates for completion of the IMRs were not given
- 7) The Nursery was not asked for an IMR
- 8) The lessons learned report:
  - a) Did not follow guidelines
  - b) Lacked attention to race and culture
  - c) Lacked analysis
  - d) Had no lessons to be learned
  - e) Did not identify the author
  - f) Referred to the mother as "DL"
  - g) Was not consistently anonymised
  - h) Did not provide a genogram, family history, or details of the father or the mother's former foster carer
  - i) Did not effectively summarise what was known by who and when
  - j) Did not attribute the origin of facts
  - k) Did not comment on the quality of IMRs
  - l) Did not identify overall themes
  - m) Did not comment on Dr AC's comment re care co-ordination
  - n) Gave a wrong or unsubstantiated conclusion
  - o) Did not analyse three review conferences
  - p) Did not give properly comprehensive and precise recommendations.

Additionally,

- q) There was a lack of recommendations for shortfalls in practice
- r) There were no recommendations about safeguarding practice in drug agencies
- s) There was lack of monitoring of the action plan
- t) IMR recommendations were not strengthened or clarified.

Evidence was gathered from the original overview report, individual management reviews, Ofsted's evaluation letter of 4 September 2008, Bradford's SCR procedures, Panel meetings, analysis of the original IMRs, the resubmitted reviews, the new IMR from the safeguarding unit and information that has come to light in the intervening period.

The Panel has developed its own skills and a process by which future SCRs will be conducted.

## **Terms of Reference and Scope of the Review of the HD SCR**

1. The Review of the HD SCR arises as a result of an overall Ofsted evaluation of "inadequate" made in September 2008.
2. Bradford Safeguarding Children Board was required on the 1 December 2008 – following a letter from the Secretary of State for Children, Schools and Families – to reconvene an Overview Panel (OP) in order to review and address the identified shortcomings of the original SCR.
3. An independent chair of the reconvened OP was identified and appointed on 5 January 2009. He is Mr Paul Sharkey, Safeguarding Manager to the Calderdale Safeguarding Children Board.
4. An independent author for the Ofsted review report was identified and appointed on 17 December 2008. He is Mr Barry Raynes, an independent consultant from Reconstruct Ltd.
5. The overarching purposes of this Review are:
  1. To establish whether there are lessons to be learned from the HD case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
  2. To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
  3. More specifically, to effectively address the issues rated as inadequate in the HD Ofsted evaluation.
  4. To include those reviewed issues from the relevant IMR into the overall SCR analysis.
  5. To generate appropriate conclusions and recommendations based on the revised SCR analysis.
  6. As a consequence, to improve inter-agency working and better safeguard and promote the welfare of children in the Bradford local authority area.

## **Scope of the Review**

6. The Review will address all the issues identified by the Ofsted evaluation report and the questions posed in the letter of 16 December 2008 from the Minister of State, and will identify further lessons to be learned. The Panel decided that due to the complexities of the case and the fact the original review was so poor, it would split this process into two parts:

1. completion of this review report by an independent author by 28 February 2009, and
  2. completion of a BSCB-wide "lessons learned" report by Bradford's safeguarding manager.
7. In relation to the lessons learned report, the issues to be addressed are:
- 7.1. To follow the guidance as set out in Working Together 8.28.
  - 7.2. Consistent reference to the mother as SR.
  - 7.3. SR will be invited to contribute her wishes and feelings to the Review. A relevant professional will be identified to visit SR in prison. The prison authorities will be approached to facilitate this visit.

The lessons learned report will:

- 7.4. Effectively edit the child's name and refer to it as Child A.
- 7.5. Include a genogram and family history.
- 7.6. Include a consideration of the respective roles of the step-father to HD and the mother's former foster carer.
- 7.7. Seek to interview these two people in relation to their role in HD's care.
- 7.8. Effectively summarise what was known by each agency and at what stage.
- 7.9. Offer a robust and rigorous analysis which will explicitly include the content and findings of individual management reviews.
- 7.10. Include commentary as to the quality and sufficiency of the six IMRs judged as inadequate.
- 7.11. Include commentary and analysis of the findings, in Dr AC's report in relation to failures in care co-ordination and the care offered by drug agencies. These are key issues.
- 7.12. Critically review the original SCR conclusion that the oversight of HD's care was carried out by all agencies in an appropriate way. This conclusion appears not to be fully substantiated by all of the findings in the original SCR overview report.
- 7.13. Include a view as to whether, in relation to the three review conferences in 2006, multi-agency decision making was sufficiently robust.
- 7.14. Take a view as to whether there was evidence that the possibility of care proceedings was considered.

- 7.15. Revisit the post-mortem findings that HD had ingested methadone and non-prescription drugs before his death. It will include a reconsideration of the extent to which professionals "should have noticed something was amiss before HD died".
- 7.16. Translate these lessons into a limited number of key recommendations that are clear, focused, SMART and capable of being implemented. Such recommendations will be sufficiently comprehensive and far reaching.
- 7.17. Take a view in respect of those IMRs where shortfalls in practice were identified but no recommendations were made. Particular attention will be paid to developing a recommendation to strengthen awareness of safeguarding responsibilities in agencies providing support to combat drug abuse.
- 7.18. A SMART action plan based on the recommendations will be produced. This will follow the NSPCC guidance "Safeguarding through audit" (see pages 18-23) and will include the specific monitoring and reviewing arrangements of the BSCB.
8. In relation to the IMRs the following agencies will be requested to resubmit their reports so that they are fully compliant with Working Together 2006 Guidance at paragraphs 8.21 to 8.27:
- Bradford Children's Social Care
  - Bradford and Airedale Primary Care Trust
  - Ripple Day Treatment Programme
  - Caleb
  - The Fair Weather Project
  - The Home Key Project
9. Those agencies whose IMRs were deemed adequate or good will not be required to re-submit their reports. These IMRs will be included in the lessons learned report.
10. Two additional IMRs have been requested from:
- The Day Nursery attended by HD
  - The Bradford Children's Safeguarding and Reviewing Unit.

11. All IMRs will be returned to the BSCB Safeguarding Manager in electronic form by 30 January 2009.
12. In addition to addressing the terms of reference of this review, they should also fully address the specific shortcomings identified in the Ofsted evaluation report of 4 September 2008.
13. Agencies are reminded of the need to have IMR authors who are independent of immediate line management of the services involved.
14. In regard to the specific shortcomings in the original Bradford Social Services IMR, the re-submitted document should address:
  - The effectiveness of the child protection plan in regard to the extent to which it was outcomes focused and properly progressed and addressed
  - The effectiveness of inter-agency involvement
  - The quality of information sharing
  - The quality of decision making
  - Whether relevant policies and procedures were followed
  - An analysis and evaluation of multi-agency risk assessment
  - Inter-agency communication
  - Inclusion of a recommendation in relation to the lack of a process to review decision making when a child has been the subject of a child protection plan for two years.
15. In regard to the Bradford and Airedale Teaching PCT, the following issues will be addressed:
  - An insufficiently rigorous analysis around for example whether the three periods when the child was not seen for two months each time were compliant with the protection plan
  - No comment regarding the assessment of HD's development progress
  - His relationship with his mother
  - The degree to which the service had a clear focus on the impact of the mother's drug use and lifestyle on her parenting.
16. In regard to expert opinion and independent knowledge the review report of Dr AC, a drugs specialist, will be incorporated into the Lessons learned report and action plans.
17. The time period of the Review and all IMRs will be from the date when agencies became aware that SR was pregnant (October 2003) to the date of HD's death on 16 July 2006. SR's social history and background in addition to the circumstances of the removal of her two previous children will also be considered.

18. The agencies included in sections 8 and 10 will be included in the Review in addition to those who have provided adequate/good IMRs, namely:
  - Bradford and Airedale Teaching PCT in respect of GP Records (Adequate)
  - Bradford Teaching Hospital Foundation Trust (Adequate)
  - West Yorkshire Police (Adequate)
  - West Yorkshire Probation Board (Good)
  - Substance Misuse Service (Adequate)
  - Bradford Drugs Interventions Programme (Adequate)
  - Also, Dr AC's report (Good).
19. There are no parallel investigations of practice.
20. There are no other LSCBs involved in this case.
21. There are no outstanding criminal, civil or coronial proceedings in this case. SR received a custodial sentence for manslaughter and child cruelty in November 2007. She is serving a three year sentence in HMP Send.
22. There are no other types of reviews.
23. In relation to the voluntary agencies (Caleb, Fair Weather Project) and smaller statutory drug agencies the BSCB has provided mentoring and support in the rewriting of IMRs.
24. The review started on the 1 December 2008 following the Secretary of State's request for all LSCBs to reconvene overview panels for those reviews deemed inadequate.
25. It will be completed by the week beginning 23 February 2009, to be received by the Secretary of State by 27 February 2009.
26. Media and Family handling strategy to be discussed.
27. Independent legal advice is not required.

### **3 Analysis**

This section will examine what action has been taken by the LSCB and its partners to address the specific weaknesses outlined in the evaluation letter from Ofsted.

Many of the criticisms relate to the process of the SCR. These have been addressed by Bradford's Child Protection Procedures section on Serious Case Reviews. This is itself in the process of being updated in the light of Ofsted's descriptors for "outstanding" SCRs by the independent author of this report.

#### **3.1 Terms of Reference**

"The terms of reference for the review are not fully comprehensive" (Ofsted evaluation letter, 4 September 2008)

The Panel accepts that the original terms of reference were inadequate and that this went a long way to contributing to the problems. Bradford's Child Protection Procedures section on Serious Case Reviews contains text about terms of reference, included as appendix one to this report.

These procedures were published on the web-site in November 2008 and can be accessed via

[http://www.proceduresonline.com/bradford/scb/chapters/psercas\\_e\\_rev.htm](http://www.proceduresonline.com/bradford/scb/chapters/psercas_e_rev.htm)

Had these procedures been in place in 2006 many of the problems would not have arisen. The Panel have taken the view that the section on terms of reference in Bradford's Child Protection Procedures needs to be strengthened following guidance from the Safeguarding Advisers Network. This would mean the additional consideration of the factors contained in appendix two of this report.

The Panel suggests that the terms of reference devised for the lessons learned report contained in this report is evidence of an increased awareness of the importance of drawing up robust terms of reference.

The Panel believes that the original terms of reference were poor because there was no detailed guidance available at that time; it was practice that one agency did not challenge another; and the original SCR panel lacked expertise.

### **3.2 Delay**

".....the completion of the review was significantly delayed" (Ofsted evaluation letter, 4 September 2008)

The delay in the original review was caused by the fact that the process was taking place at the same time as the trial, and many files were held by the police. The Panel recommends that there should be national guidance to deal with such an occurrence.

Bradford's present child protection procedures section on SCRs stresses the need for complying with *Working Together* timescales. They are included as appendix three.

The Panel has established a precedent in that it set a timescale for IMRs to be produced and this was met. The Panel returned two IMRs to the authors because of poor quality. These matters will be included in the lessons learned report. Recommendations from both that report and this one will be fed into BSCB's business planning cycle.

There is now a template used for IMRs and a mentoring system has been established for future IMR authors.

BSCB now recognise that Government Offices must be informed of any unavoidable delay in SCRs.

### **3.3 Lack of independence**

"The author of the overview report is not identified therefore it has not been possible to make a judgement about the level of independence built into the process" (Ofsted evaluation letter, 4 September 2008).

The Panel accepts the criticism that there was insufficient independence in the original SCR process. The overview author in the original SCR was also the Chair, independent of the case but not independent of Bradford SCB.

Bradford's child protection procedures section on SCRs is not clear about the need for differentiation between Panel chair and overview author:

"Who should be appointed as the independent Chair of the Overview Panel and the author for the Overview report"? (paragraph 6.6).

This guidance is ambiguous, it could mean that the chair and the author are the same person or that they are different people. The Panel recommends that it is rewritten as:

“Who should be appointed as the independent Chair of the Overview Panel and, in addition, who should be appointed as the author for the overview report?”

The Panel recommends that guidance is also drafted that clarifies the relative roles of the independent chair and overview author, how they will be commissioned, what quality assurance systems need to be in place and what will happen in the event of disagreements between author, chair and Panel.

### **3.4 Poor involvement of family members**

“There is also no indication whether the mother or any other relatives were informed of the review or whether they were invited to contribute to it” (Ofsted evaluation letter, 4 September 2008).

The Panel now accept that the real involvement of family members is crucial in identifying themes that need to be addressed. Bradford’s Child Protection Procedures section on Serious Case Reviews asks:

“How should family members contribute to the review and who should be responsible for facilitating their involvement?” (paragraph 6.6).

The Panel recommends that Bradford’s Child Protection Procedures section on Serious Case Reviews needs to contain reference to “significant others” as these can provide considerable help in analysing situations of older children. However, information from significant people may have been made available to the police in the process of their investigation. Therefore the Panel recommend that there be a protocol agreed between the police and SCR Panel whereby such information can be shared.

There was inadequate involvement of family members in this case. However there is evidence to support the fact that SR was asked to contribute to the review and was sent a copy of the executive summary and asked to comment. She declined on both occasions because she feared that the involvement would interfere with her trial.

The Panel recognise that the involvement of family members can be adversely affected by the timescales laid down in *Working Together to*

*Safeguard Children* (2006). In the first five months after the incident family members are grieving and often involved in other processes.

The Panel are pleased to note that SR has agreed to be involved in the rewrite of the lessons learned report, saying that she wishes to give information that will protect children in the future. Bradford's safeguarding manager will visit her in March.

An interesting development in this process has been the willingness of SR to come forward and discuss with Bradford's Safeguarding manager the services that she received, despite the fact that she refused to do so during the original SCR process. This leads the Panel to consider the fact that parents are less likely to engage in the SCR process when they are still grieving or if they are involved in criminal proceedings relating to the incident that led to the SCR. The Panel will therefore request that BSCB considers discussing this issue with Ofsted.

### **3.5 The IMRs were not systematically analysed**

"There is little evidence that (the IMRs) have been systematically analysed" (Ofsted evaluation letter, 4 September 2008).

The Panel accepts that not enough attention was paid to the quality of the IMRs and that the overview author did not analyse each report in the required detail. The requirement to allow overview authors to be critical of the IMRs they receive has been spelt out by Ofsted since this review was completed. BSCB has now accommodated this change in practice and the Panel recommends that the Child Protection Procedures be updated to reflect this.

For this review IMR authors have presented their reports to the Panel and their findings and analysis have been discussed and analysed. The Panel recommends that the Child Protection Procedures be updated to reflect this process.

Guidance should be added on the requirement for the overview report to critically assess IMRs and for the Panel to ensure quality control.

### **3.6 Dates for completion of the IMRs were not given**

“However a date for completion of these (the IMRs) reviews was not given” (Ofsted evaluation letter, 4 September 2008).

The Panel accepts that this was an oversight. The new terms of reference that will be used by Bradford following this process will clearly state deadlines for IMRs to be returned. It should be noted that the deadline for return of six IMRs during the re-review process was 30 January 2009 and all were received by that date.

### **3.7 The Nursery was not asked for an IMR**

“Given that HD had a place at a day nursery, and was expected to attend regularly, it is not clear why this nursery was not invited to complete an individual management review” (Ofsted evaluation letter, 4 September 2008).

The Panel accept that this was an oversight. The present guide to compiling terms of reference state:

“Which organisations and professionals should contribute to the Review, including, where appropriate, for example, should the proprietor of an independent school, playgroup leader be asked to submit reports or otherwise contribute?” (paragraph 6.6).

The SCR panel should think widely in terms of who to invite. However it is often the case that agencies were involved in the case but this only becomes apparent as the SCR process unfolds. The Panel therefore recommend that there be a standing list of statutory and voluntary agencies who are contacted at the beginning of the SCR process and asked whether they have had any contact with the family. The guidance will be updated to include this.

Mr. Hill (BSCB Safeguarding Manager) has visited the Nursery to look at their files and discuss this case with them. The files are not available as the police took other records at the beginning of the criminal investigation and they have still not been returned. The Panel accept therefore that BSCB agree a protocol with police whereby they make information available to the SCR panel in a timely manner to ensure that delay is not created. The Panel believe this will be an issue for other Safeguarding Boards.

### **3.8 The overview report did not follow guidelines in *Working Together 1999***

"The overview report is inadequate and did not follow the guidance set out in *Working Together*" (Ofsted evaluation letter, 4 September 2009).

The Panel accept that the original report did not follow the guidelines in *Working Together* and accept that the present guidance does not adequately address the actual production of overview reports. This will be addressed in the redrafting of the terms of reference section in Bradford's Child Protection Procedures section on Serious Case Reviews.

### **3.9 The overview report lacked attention to race and culture**

"It does not consider the extent to which practice was sensitive to cultural, racial and linguistic and religious identity" (Ofsted evaluation letter, 4 September 2008).

The Panel accepts that this issue was lacking in the original report. The rewritten IMRs have expressly addressed the question

*"was practice sensitive to the racial, cultural, linguistic identity of the child and family?"*.

The Panel have recommended that a question of this nature should be a standing item for all IMRs and overview reports but that it should be reworded as the following open question:

*"How did the agency respond to the racial, cultural, linguistic identity of the child and family?"*

SR and HD were in fact dual heritage, white British/Asian. The lessons learned report will be in a position to consider this in more detail.

The Panel have noted that the SCR recently submitted to Ofsted received positive feedback about its attention to these issues.

### **3.10 The overview report lacked analysis**

*"The report is lacking in analysis and rigour"* (Ofsted evaluation letter, 4 September 2008).

The Panel accepts that the original overview report was of a poor standard. It is the Panel's view that many writers require guidance on analysis. The redrafted IMRs for this report contained the requirement under "analysis" to answer a series of questions. These were: -

1. Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child?
2. Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare? What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
3. Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments? Were the assessments/actions completed within timescales?
4. Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
5. When, and in what way, were the child(ren)'s wishes and feelings heard and addressed? Was this information recorded?
6. Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?
7. Were more senior managers, or other organisations and professionals, involved at points where they should have been?
8. Was the work in this case consistent with the organisation and LSCB policy and procedures for safeguarding and promoting the welfare of children, and wider professional standards?

The problem that this caused was that most of the IMR authors answered the questions but failed to analyse any other issues. This reduced their ability to hypothesise on any themes that may have emerged from the case summary. Bradford's guide to serious case reviews does not contain guidance on analysis and this will be addressed in the next draft.

In this new review IMR authors have been interviewed by the Panel and this has brought out key themes that will be developed in this report and in the lessons learned report.

The Panel have learned that good analysis comes about because authors have been given time to consider the information that they have gathered in a critically reflective environment, namely being interviewed by the Panel.

Rather than include narrow questions in the analysis section, the Panel advises that the guidance on completing serious case reviews has the question:

“Having read the files and produced a chronology why do you think the incident occurred and what do you think could have been done to avoid it?”

Good analysis involves answering “why” questions. It is often necessary to interview staff and family members to discover the answers to “why” questions. For example a reading of the file may elicit the fact that procedures were not followed, but the staff member will have to be interviewed to discover why not. These themes have been further developed in SCIE’s 2008 document *Learning Together to Safeguard Children*.

### **3.11 The overview report had no lessons to be learned and did not identify overall themes**

The Panel accept this criticism. This will be addressed in this report following the rewriting and re-analysing of the IMRs.

Bradford’s Child Protection Procedures section on Serious Case Reviews mentions “lessons” but fails to suggest that these should be specific and should lead to recommendations. This will be addressed in the redraft of Bradford’s Child Protection Procedures section on Serious Case Reviews.

### **3.12 The overview report author was not identified**

The Panel accepts this criticism. Bradford’s Child Protection Procedures section on Serious Case Reviews does not contain specific guidance on writing the overview report. The template for IMRs contains the requirement that reports should be signed, dated and signed off by senior managers. This will be replicated on the format for the overview report.

### **3.13 The mother was referred to as “DL” in the overview report and the overview report was not consistently anonymised**

The Panel accepts this criticism. This has been addressed in the rewrite of the IMRs and requirements to use anonymised and consistent initials will be

contained within Bradford's Child Protection Procedures section on Serious Case Reviews.

### **3.14 The overview report had no genogram, no family history, no consideration of mother's former foster carer**

The Panel accepts this criticism. This has been addressed by requesting each IMR author to develop a genogram. Requirements to contain a genogram will be contained in Bradford's Child Protection Procedures section on Serious Case Reviews. In future terms of reference for serious case reviews will request that information be sought from the point at which parents as well as children begin contact with social care or other, non-universal, agencies. This would mean that foster carers would, in future, be included.

### **3.15 The overview report did not effectively summarise what was known by who and when**

"The overview report does not effectively summarise what was known by which agency and at which stage" (Ofsted evaluation letter, 4 September 2008).

The Panel accepts this criticism. Guidance on summarising what was known by whom and when will be added to Bradford's guide to producing Serious Case Reviews.

### **3.16 The overview report contained facts which were not accredited**

".....the source of findings from individual management reviews is not explicitly included" (Ofsted evaluation letter, 4 September 2008).

The Panel accept this criticism. This problem often arises when the Panel Chair and report writer are the same person. Bradford's Child Protection Procedures section on Serious Case Reviews will contain advice on ensuring that fact and opinion are separated and that all facts are accredited.

### **3.17 The overview report made no comment on the quality of IMRs**

The Panel accepts that not enough attention was paid to the quality of the IMRs and that the overview author did not analyse each report in the required detail. The requirement to allow overview authors to be critical of the IMRs they receive has been spelt out by Ofsted since this review was completed and Bradford's redrafted guide to serious case reviews will reflect this.

### **3.18 The overview report made no comment about Dr AC's comment re: care co-ordination**

"There is no comment in relation to the findings by Dr AC in relation to failures in care co-ordination and the care offered by drug agencies" (Ofsted evaluation letter, 4 September 2008).

This will be addressed in the lessons learned report.

### **3.19 The overview report failed to analyse the three review conferences**

"In relation to the three review conferences in 2006, no view was taken as to whether multi-agency decision making was sufficiently robust and if there was evidence that the possibility of instituting care proceedings was considered" (Ofsted evaluation letter, 4 September 2008).

This has been addressed by the creation of an individual management review from Bradford's Children's Services Safeguarding and Reviewing Unit, the team responsible for supplying independent chairs of child protection case conferences. The Panel judge this to be a good IMR and this has led to further lessons to be learned and new recommendations many of which have already been commented on.

### **3.20 The overview report recommendations were not properly comprehensive and were imprecise**

The Panel has requested that the lessons learned author re-analyses the original recommendations and draws up new recommendations following a re-analysis of the case. Bradford's guide to serious case reviews contains the following:

"To ensure clear, robust, meaningful recommendations that will bring about service change" (paragraph 9.6)

"Focus recommendations on a small number of key areas, with specific and achievable proposals for change and intended outcomes", (paragraph 13.1).

The Panel believes that this will assist authors in producing more precise recommendations though it regrets the use of the word "robust" as this is too general.

### **3.21 The overview report had a lack of recommendations for shortfalls in practice**

The Panel accepts this point and notes that it follows on from the fact that the original SCR came to incorrect conclusions. The Panel believes that this new review has produced appropriate recommendations and believes that further analysis will ensue during the drafting of the lessons learned report.

### **3.22 The overview report made no recommendations about safeguarding practice in Drug agencies**

The Panel accepts this point and notes that it follows on from the fact that the original SCR came to incorrect conclusions. The Panel believes that this review has produced appropriate recommendations and believes that further analysis will ensue during the drafting of the lessons learned report.

### **3.23 The overview report failed to determine the monitoring of the action plan**

The Panel accepts this point and notes that it follows on from the fact that the original SCR came to incorrect conclusions. The Panel believes that this review has produced appropriate recommendations and believes that further analysis will ensue during the drafting of the lessons learned report.

Bradford's serious case review guide states:

"The LSCB should review and monitor agency Action Plans and put in place a means of auditing action against recommendations and intended outcomes" (paragraph 13.1).

The Panel believes that this will assist in monitoring action plans but recommends that the guide should include model headings for action plans and that the SCR action plans should, themselves, integrate into the LSCB business plan.

### **3.24 The IMR recommendations were not strengthened or clarified in the overview report**

The Panel accepts this point and notes that it follows on from the fact that the original SCR came to incorrect conclusions. The Panel believes that this review has produced appropriate recommendations and believes that further analysis will ensue during the drafting of the lessons learned report.

### **3.25 The overview report either came to the wrong conclusions or did not properly substantiate its own conclusions**

"The conclusion that the oversight of HD's care was carried out by all agencies in an appropriate way is not substantiated by all the findings" (Ofsted evaluation letter, 4 September 2008).

The Panel accepts that the original overview came to the wrong conclusion. There were the following failings in the practice and communication in this case:

1. Failure to take account of history
2. An inability to view the case differently despite lack of progress
3. Lack of a core assessment of the child
4. Taking SR's self reporting about drug use at face value
5. Lack of communication between drugs and children's workers
6. Lack of co-ordination among the drugs workers themselves
7. Lack of a relapse plan
8. Lack of a "working with drug using parents" procedure
9. Too much time spent in the child protection conference talking about information and not enough time spent on analysis
10. Child protection plans were not based upon objectives and were allowed to drift.

The lessons learned report will expand upon these issues in more detail but the general points are as follows.

**1 Failure to take account of history.** The Panel noted that the lack of attention paid to the historical information has been described as "start again syndrome", particularly constant in cases of neglect (see Marion Brandon in *Analysing Child Deaths and Serious Injury through Abuse and Neglect : What can we Learn?* (UEA/DCSF, Brandon M , Belderson J, Warren C, Howe, D, Gardner R, Dodsworth J, and Black J, 2008)).

The reconstituted Panel has interviewed the IMR writers and concluded that insufficient weight was given to the removal of SR's two older children. The original SCR's terms of reference set the period to be examined from the birth of HD, thus repeating this error. The original terms of reference for this re-review set the same timescale, nevertheless Bradford's safeguarding manager has read the earlier files.

The decision about the lack of relevance of the removal of the two older children was made by the case workers on the basis that they had been removed because SR had been in an abusive relationship with a partner who

had hit the children. This relationship had ended some time ago and the new case workers decided that there was no relevance to this decision. However, further analysis of the earlier files by Bradford's safeguarding manager has uncovered the fact that there were considerable concerns about SR's parenting ability. The Panel considers that the earlier case workers were possibly failing to take account of history, and emphasising event over context.

The Panel therefore concludes that this can be included as lessons to be learned, while accepting that this is a recurring theme in child protection reviews.

***2 An inability to view the case differently despite lack of progress.***

The Panel has come to the view that the positive reports at the first child protection conference were optimistic and this optimism continued throughout the case. This is a lesson first commented upon by Dingwall (1985) after the Jasmine Beckford Inquiry as the "rule of optimism". However Munro (1999) concluded that this is more about the failings of human beings to change their minds, and she evidences occasions when workers start off with a negative view of a case and refuse to alter the plan despite facts emerging that demonstrate that a more optimistic view should be taken. The Panel believes that reflective supervision is important in addressing this issue.

***3 A lack of re-assessment of the child.*** HD was seen regularly by workers and his demeanour was commented on. However, the original core assessment was never adequately updated. The Panel recognised that, given the "start again syndrome" and the rule of optimism that may have been operating, it is unlikely that a core assessment from the professionals working with HD would have resulted in a change of plan or attitude.

***4 Taking SR's self reporting about drug use at face value.*** SR was telling different stories to children's and drugs workers about her drug use, telling the children's workers that her drug use was less than what she was telling the drugs workers. The children's workers took this information at face value, failing to check this with the drugs workers.

***5 Lack of communication between drugs and children's workers.*** Drugs workers' attendance at child protection conferences was "sporadic" according to the new IMR from the Safeguarding Unit. There were thirteen agencies involved in this little boy's life, thus complicating the communication issues. However, resolving the next issue would provide some assistance.

**6 Lack of care co-ordination amongst the drugs workers**

**themselves.** There were a number of drugs agencies involved but there did not appear to be a care co-ordinator. According to the report from Dr. AC this role should have fallen to the drugs worker at City SMS, as she was in a position to liaise with both the prescribing doctor and the other agencies involved in drug treatment.

**7 Lack of a relapse plan.** People recovering from any addiction will inevitably relapse during the course of their rehabilitation. The child protection plans failed to have any contingencies regarding relapse of mother and protection of HD.

**8 Lack of a “working with drug-using parents” procedure.**

The Panel are pleased to note that Bradford’s new Child Protection Procedures have a clear policy on working with children of drug-using parents. These can be accessed at

[http://www.proceduresonline.com/bradford/scb/chapters/p\\_ch\\_drug\\_mis\\_pa\\_r.html](http://www.proceduresonline.com/bradford/scb/chapters/p_ch_drug_mis_pa_r.html)

**9 Too much time spent in child protection conference talking about information and not enough time spent on analysis.** The Panel believes that the minutes of the child protection conferences demonstrate that too much time was spent on discussing information with not enough attention paid to analysis, monitoring and reviewing child protection plans.

**10 Child protection plans were not based upon objectives and were allowed to drift.** The Panel has seen the child protection plans and accepts that they are a list of tasks without desired outcomes. This makes it more difficult to review progress as it is possible to complete a task without achieving the outcome. Indeed the Panel believes that the child protection plan was implemented more as a “child in need” plan, in that there was no provision in it to escalate to care proceedings. This reflects a common theme identified in *Learning Lessons, Taking Action* (Ofsted 2008), which states that the focus on the common assessment framework “makes it even more critical that all staff are aware of child protection issues” (page 25, para. 62).

## **4 Lessons to be learned**

From reading the overview report and individual management reviews, subsequent discussions conducted by the Panel, and further investigation by Bradford’s Safeguarding Manager Paul Hill, the Panel concludes that the death was not predictable but may have been preventable.

This is based on the acceptance that the staff in place did not have enough skills to recognise the effect of methadone ingestion on babies. The Panel is itself unaware of research which would assist staff in this recognition. However, the death may have been preventable as there were a number of factors that should have alerted staff to the fact that HD was not best placed permanently with his mother. These were:

1. Previous children had been removed,
2. There was a lack of progress in reducing drug use, and
3. There was evidence that SR was deceiving staff,
4. SR admitted to using drugs in front of HD.

The lessons to be learned concern casework, child protection conferences, working together, training and case recording.

#### **4.1 Casework**

1. Staff:
  - a. did not give enough thought to how a parent's drug use may affect children, or what the effect will be as children get older
  - b. paid little attention to the mother's dishonesty
  - c. did not have relapse plans, did not regularly re-assess drug use, and seemingly had no awareness of the links between these issues and the child protection plan
2. Risk assessments of drug using parents did not include risks to children.
3. Staff had limited knowledge of the effects of methadone.
4. Workers paid little attention to HD's racial, cultural, linguistic and religious background and the impact of this.

#### **4.2 Review conferences and core group meetings**

1. The conferences did not give sufficient consideration to SR's ability to maintain a drug treatment programme.
2. Conference minutes concentrate on the reports of attendees as opposed to analysis.
3. Chairing child protection conferences without a minute taker is ineffective.
4. Legal services were not involved in the child protection conferences.
5. Team Managers rarely attend a Case Conference Review meeting.
6. Action points were not always acted on and reviewed.
7. Core group meetings are not always held to required timescales.
8. HD's name was on the register for two years but no specific action was taken to review whether an alternative plan should be put in place.

9. More emphasis needs to be given to the assessment of the role of partners who join families in the parenting of children.

#### **4.3 Working Together**

1. Workers do not always have enough dialogue with each other.
2. HD's non-attendance at nursery was not closely monitored.

#### **4.4 Training**

Training does not cover visible signs of drug use on an infant.

#### **4.5 Case recording**

1. Case recording systems need updating.
2. Written records of all contact must be kept and confirmed including telephone calls.
3. Regular audits of files should ensure all paperwork is being done correctly.
4. Record keeping is sometimes unclear, ambiguous, not contemporaneous and makes inappropriate use of exclamation marks.

### **5 Have the lessons to be learned been appropriately translated into recommendations?**

1. Work with drug using parents should include:
  - a. consideration about how a parent's drug use may affect children and what the effect will be as children get older.
  - b. consideration of the fact that parents can be deceptive.
  - c. relapse plans, the need to regularly re-assess drug use, and consideration of how relapse impacts on the child protection plan.
2. Risk assessments of drug using parents should include consideration of risks to children.
3. Increase staff's knowledge about the effects of methadone.
4. Ensure that all workers pay attention to children's racial, cultural, linguistic and religious background and the impact of this.
5. Ensure that conference chairs give sufficient consideration to a drug using parent's ability to maintain a drug treatment programme.
6. Ensure that conference discussions focus upon analysis.
7. Ensure that chairs of meetings don't take minutes.
8. Clarify the relationship between Legal and children's services.
9. Ensure that team managers attend Case Conference Review meetings.
10. Improve monitoring of child protection plans to ensure action points are always acted upon and reviewed.
11. Ensure that core group meetings are held to required timescales.

12. Develop practice guidance for action to be considered when a child has been on the register for 18 months which involves consideration of the case by an independent audit and panel.
13. Develop practice guidance on the assessment of the role of partners who join families in the parenting of children.
14. Ensure that multi-agency training stresses the importance of dialogue between workers rather than a focus on sharing information.
15. Clarify the role of all staff when children are subject to child protection plans.
16. Improve training so that it covers visible signs of drug use on an infant.
17. Update case recording systems.
18. Emphasise to staff the importance of keeping written records of all contact including telephone calls.
19. Regularly audit files to ensure all paperwork is being done correctly.
20. Ensure record keeping is clear, unambiguous, contemporaneous and does not make inappropriate use of punctuation marks.
21. Clarify the role of care co-ordinators in the Drug field.

Additionally the following recommendations come from the Ofsted evaluation:

20. To update Bradford's Serious Case Review guide to:
  - a. include terms of reference
  - b. provide clarity around the separation between overview author and chair
  - c. add "friends" to consideration about who should be involved in the SCR process
  - d. include a mandate for the independent overview author and SCR panel to critically assess IMRs
  - e. redraft race and culture question to be an open question
  - f. include further guidance on analysis
  - g. emphasise that "lessons to be learned" should be a standard heading in IMRs and overview reports
  - h. Provide headings for action plans
  - i. Clarify the relationship between action plans and the LSCB business plan
  - j. produce guidance on writing overview reports. Reports should:
    - i. identify authors and be dated
    - ii. be signed off by the Chair of the SCR Panel
    - iii. consistently use initials to identify children and family members,
    - iv. contain a genogram

- v. summarise what was known and by whom
  - vi. identify the origin of facts
  - vii. critique IMRs.
21. Request that Ofsted provide guidance on managing the interface between criminal proceedings and the SCR process.
  22. Child protection plans of children of drug using parents must include information about how their drug use can affect the child and what the consequences of escalating drug use will be.
  23. The Panel recommends that a guide be developed on child protection plans to emphasise that all such plans contain clear analysis of risks to the child, steps to be taken to reduce that risk and a consideration of the desired outcomes for the child. The plans should contain indicators that describe failure or success and indicators that suggest when the case should be considered for an application to court or when the child should be given a child in need plan.
  24. Bradford Safeguarding Children Board should further consider the implications of requesting that children of drug using parents be regularly tested for drug ingestion.

## **6 How the impact of this has been monitored**

Bradford Safeguarding Children Board have made many changes since HD's death and these have been listed throughout section 3 of this report.

Many of these responses have been embedded in practice; for example the greater links between drugs and children's workers.

Much work has taken place in Bradford since the receipt of the Ofsted evaluation letter. This has focused on the process of conducting serious case reviews, as well as the specifics of the case of HD. These recommendations have been built into action plans and will be monitored through the serious case review group.

This report contains further recommendations and Bradford Safeguarding Children Board will consider these in April. Those that are accepted will be built into the Board's business plan.

## **7 How the "inadequate" judgment has been used to inform any other SCRs which may be required over time.**

Bradford Safeguarding Children Board have taken the inadequate judgement very seriously. They have accepted that all the criticisms of Ofsted, in their letter of 4 September 2008, are valid.

After receipt of the letter from the Minister of State, they set up a new Panel to reconsider the case and this group have met on five occasions. Much of the time was spent discussing the issues of the original case rather than the process of serious case reviews. However the outcome of this deliberation has been the emergence of a thorough and analytical process of conducting future serious case reviews in the future. This involves the interviewing of IMR authors and staff and a greater commitment to involving family members.

The independent author has expressed concern that the learning may be confined to the people who attended the Panel meetings, but has been assured that the learning will be reflected in the update of the serious case review procedures which is currently taking place. Furthermore the information and recommendations contained in this review will inform that rewrite.

Following the submission of the HD serious case review, Bradford Safeguarding Children Board, via its standing serious case review sub group, took the following steps to improve the quality of future serious case reviews:

1. Development and Implementation of a pro forma for individual management reviews;
2. A serious case review sub group became responsible for developing terms of reference for Serious Case Reviews.

A second serious case review (AI) was completed and submitted to OFSTED in October 2008. The developments described above were in place when this serious case review was initiated, and it was subsequently evaluated overall as "adequate".

The OFSTED evaluation demonstrates the positive impact of the above initiatives, stating that: "the terms of reference were clear and comprehensive, and cover relevant issues... they provide a solid basis for subsequent analysis".

Furthermore, despite the fact that a number of the individual management reviews in this subsequent serious case review were individually evaluated as inadequate, it is noted from the evaluation letter that "all (SCRs) are suitably anonymised and follow a standard pro forma and provides a helpful basis for the overview report".

The standing serious case review sub-committee has built on these initiatives by reviewing and revising the Bradford Safeguarding Children Board serious case review procedures, drawing on the support of the Safeguarding Advisor for Regional Government Office for Yorkshire and Humber in this process. These revised procedures were published in November 2008 and incorporated:

1. A clear requirement for the chair and author of the serious case reviews to be fully independent of the LSCB and its agencies
2. Involvement of the Regional Government Officer Safeguarding Advisor in supporting the serious case review sub group in developing terms of reference for serious case reviews
3. Confirming the timescales for completion of serious case reviews set out in *Working Together to Safeguard Children 2006*, and describing where necessary the process of seeking extension to these timescales from Regional Government Office
4. The requirement to consider how to involve family members in the process
5. Responsibility of the Bradford Safeguarding Children Board SCR sub group to monitor the action plans arising from the overview report recommendations. The Bradford Safeguarding Children Board SCR sub group has made a local agreement involving the Regional Government Office Safeguarding Advisor in the review of these plans.

It is acknowledged that these procedures will require further revision following the government's response of the safeguarding arrangements currently being undertaken by Lord Laming.

Bradford's Safeguarding Children Board serious case review sub group has made further developments to try to ensure continuous improvement to serious case review processes. These were agreed at its meeting on 12 February 2009, and focus in particular on strengthening and improving the quality of agencies' individual management reviews.

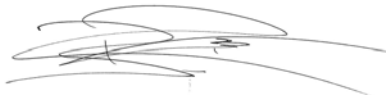
The key steps are:

1. Nominated managers have been identified by each Bradford Safeguarding Children Board agency who will receive training and regular briefings regarding individual management reviews and serious case review processes.
2. Independent training has been commissioned to be delivered twice in early summer and early autumn 2009 for individual management review authors. This training will be provided by Jane Wonnacott Associates.
3. At the point of commencing each new serious case review there will be specific briefing sessions for the independent chair of the SCR with the individual management review authors.
4. A mentoring arrangement for each individual management review author is to be established to provide support and challenge in the course of each serious case review.
5. Each individual management review author will be required to attend the overview panel to present the report, clarify queries, be critically challenged, and receive comments on the quality of the review submitted.

These measures are intended to help address the recurring and central issue of inadequate analysis in respect of individual management reviews.

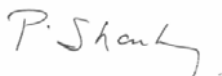
**Signatures of:**

Author Barry Raynes



Date 25/02/09

SCR Panel Independent Chair, Paul Sharkey



Date 27/02/09

Kam Tun-Yee.

LSCB Chair  
Date 27/02/09

## **Appendix one Bradford's guide to terms of reference**

1. "What appear to be the most important issues to address in trying to learn from this specific case?"
2. How can the relevant information best be obtained and analysed?
3. Who should be appointed as the independent Chair of the Overview Panel and the author for the lessons learned report?
4. Who should be appointed as members of the Overview Panel - so as to reflect the involvement of relevant agencies
5. Which organisations and professionals should contribute to the Review, including, where appropriate, for example, the proprietor of an independent school, playgroup leader should be asked to submit reports or otherwise contribute?
6. Are there features of the case which indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals/organisations who will be required to participate in the review? Might it help the Review Panel to bring in an outside expert at any stage, to shed light on crucial aspects of the case?
7. Over what time period should events be reviewed, i.e. how far back should enquiries cover? and what is the cut-off point? What family history/background information will help better to understand the recent past and present?
8. How should family members contribute to the review and who should be responsible for facilitating their involvement?
9. Will the case give rise to other parallel investigations of practice, for example, independent health investigations or multi-disciplinary suicide reviews, a homicide review where a parent has been murdered, a YJB Serious Incident Review and a Prisons and Probation Ombudsman investigation where the child has died in a custodial setting? And if so, how can a co-ordinated or jointly commissioned

review process best address all the relevant questions which need to be asked, in the most economical way?

10. Is there a need to involve organisations/professionals in other LSCB areas, and what should be the respective roles and responsibilities of the different LSCBs with an interest?
11. How should the review process take account of a Coroners Inquiry, and (if relevant) any criminal investigations or proceedings related to the case? How best to liaise with the Coroner and/or the Crown Prosecution Service?
12. How should the Serious Case Review process fit in with the processes for other types of reviews e.g. for homicide, mental health or prisons?
13. Who will make the link with relevant interests outside the main statutory organisations - e.g. independent professionals, independent schools, voluntary organisations?
14. When should the review process start and by what date should it be completed?
15. How should any public, family and media interest be managed, before, during, and after the review?
16. Does the LSCB need to obtain independent legal advice about any aspect of the proposed review?" (Bradford Child Protection Procedures, Paragraph 6.6).

## **Appendix two Panel's suggestion for additions to terms of reference**

1. Stressing the need for independence by the chair of the SCR Panel, allowing for a standing panel of managers independent of the case who are assisted by co-opted managers who know the case.
2. Clearly stating that timescales must follow those set out in Working Together, e.g. one month to make the decision and four months to complete the review and the requirement to liaise with Government offices in the event that unavoidable delay occurs.
3. Clarity about the ownership of the independent overview report and commissioning processes,
  - a. Which author is being proposed and why? Indicate if they have any specific skills or knowledge.
  - b. Specify in what way they are considered 'independent'.
  - c. Will LSCB require the author to use a particular format for their report and is a template available?
  - d. Specify what is expected of the author and within what timescales, maybe give some examples of things to consider e.g., dates booked in to present the early findings to the panel, dates for final report to LSCB., a link person for the author and the means by which their work will be facilitated.
  - e. Clarify process should Board fail to ratify final report.
4. Adding more about the key issues to be considered,
  - a. Are there any unusual factors in this case, what are they?
  - b. Are there similarities with previous IMRs or SCRs, what are they?
  - c. Are there any failings which appear obvious at this stage?
  - d. Do there appear to be any gaps in multi –agency working?
  - e. Are there any issues which relate to ethnicity, disability or faith which may have a bearing on this review?
  - f. Is there any known research which may assist?
  - g. Are there other SCRs in region or nationally which are similar?
5. Expert Opinion,
  - a. Are there features of the case that indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals/organisations who will be required to participate in the review?
  - b. Might it help the Review Panel to bring in an outside expert at any stage, to shed light on crucial aspects of the case?
  - c. What action will the Board take if there is a failure to cooperate with this review?
6. Legal Advice,
  - a. Does the LSCB need to obtain independent legal advice regarding any aspect of the proposed review?

### **Appendix three Bradford's guide to timescales in serious case reviews**

"Where a decision is made to conduct a Serious Case Review, the review should be completed within 4 months unless an alternative timescale has been agreed with the Regional Government Office. More time may be required, for example where the Serious Case Review concerns abuse which has taken place in an institution or where multiple abusers are involved.

Where it emerges during the course of a Review, that the timescale cannot be met, the LSCB Manager should formally request a revised timescale which must be agreed by the Regional Government Office.

In some cases, criminal proceedings may follow the death or serious injury of a child. Those co-ordinating the review should discuss with the relevant criminal justice agencies, at an early stage, how the review process should take account of such proceedings, for example how does this affect timing, the way in which the review is conducted (including interviews of relevant personnel), its potential impact on criminal investigations and who should contribute at what stage?

Serious Case Reviews should not be delayed as a matter of course because of outstanding criminal proceedings or an outstanding decision on whether or not to prosecute. Much useful work to understand and learn from the features of the case can often proceed without risk of contamination of witnesses in criminal proceedings. In some cases it may not be possible to complete or to publish a review until after Coroners or criminal proceedings have been concluded but this should not prevent early lessons learned from being implemented", (paragraph 7.1-7.4).