

- a looked after child has died (including cases where abuse or neglect is **not** known or suspected); or
- a child in a regulated setting or service has died (including cases where abuse or neglect is **not** known or suspected).<sup>52</sup>

14. The local authority should report any incident that meets the above criteria to Ofsted and the relevant LSCB or LSCBs promptly, and within five working days of becoming aware that the incident has occurred.<sup>53</sup>

15. For the avoidance of doubt, if an incident meets the criteria for a Serious Case Review (see below) then it will also meet the criteria for a notifiable incident (above). There will, however, be notifiable incidents that do not proceed through to Serious Case Review.

16. Contact details and notification forms for notifying incidents to Ofsted are [available on Ofsted's website](#).

## Serious Case Reviews

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

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

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

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

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

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<sup>52</sup> Regulated settings and services: Childcare on domestic premises; Childcare on non-domestic premises; Home childcarer; Childminder; Children's Homes (including secure children's homes); Adoption Support Agencies; Voluntary Adoption Agencies; Independent Fostering agencies; Residential Family Centres and Holiday Schemes for Disabled Children.

<sup>53</sup> For example, in the case of out of area placements where the placing authority is different from where the child's care home is based.

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

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

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

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

19. In addition, even if one of the criteria is not met, an SCR **should always** be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or 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.

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

## **National panel of independent experts on Serious Case Reviews**

21. Since 2013 there has been a national panel of independent experts to advise LSCBs about the initiation and publication of SCRs. The role of the panel is to support LSCBs in ensuring that appropriate action is taken to learn from serious incidents in all cases where the statutory SCR criteria are met and to ensure that those lessons are shared through publication of final SCR reports. The panel also reports to the Government their views of how the SCR system is working.

22. The panel's remit includes advising LSCBs about:

- application of the SCR criteria;
- appointment of reviewers; and
- publication of SCR reports.

23. LSCBs should have regard to the panel's advice when deciding whether or not to initiate an SCR, when appointing reviewers and when considering publication of SCR reports. LSCB Chairs and LSCB members should comply with requests from the panel as far as possible, including requests for information such as copies of SCR reports and invitations to attend meetings.<sup>54</sup>

24. The text which follows provides a checklist for LSCBs on how to manage the SCR process.

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<sup>54</sup> In doing so LSCBs will be exercising their powers under Regulation 5(3) of the Local Safeguarding Children Board Regulations 2006 which states that 'an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objective'.

## **Serious Case Review checklist**

### **Decisions whether to initiate an SCR**

The LSCB for the area in which the child is normally resident should decide whether an incident notified to them meets the criteria for an SCR. This decision should normally be made within one month of notification of the incident. The final decision rests with the Chair of the LSCB. The Chair may seek peer challenge from another LSCB Chair when considering this decision and also at other stages in the SCR process.

The LSCB should let Ofsted, DfE and the national panel of independent experts know their decision within five working days of the Chair's decision.

If the LSCB decides not to initiate an SCR, their decision will be subject to scrutiny by the national panel. The LSCB should provide sufficient information to the panel on request to inform its deliberations and the LSCB Chair or the Chair's representative should be prepared to attend in person to give evidence to the panel. In cases where an LSCB is challenged by the national panel to change its original decision, the LSCB should inform Ofsted, DfE and the national panel of the final outcome.

### **Appointing reviewers**

The LSCB must appoint one or more suitable individuals to lead the SCR who have demonstrated that they are qualified to conduct reviews using the approach set out in this guidance. The lead reviewer should be independent of the LSCB and the organisations involved in the case. The LSCB should provide the national panel of independent experts with the name(s) of the individual(s) they appoint to conduct the SCR. The LSCB should consider carefully any advice from the independent expert panel about appointment of reviewers.

### **Engagement of organisations**

The LSCB should ensure that there is appropriate representation in the review process of professionals and organisations who were involved with the child and family. The priority should be to engage organisations in a way which will ensure that important factors in the case can be identified and appropriate action taken to make improvements. The LSCB may decide as part of the SCR to ask each relevant organisation to provide information in writing about its involvement with the child who is the subject of the review.

### **Timescale for SCR completion**

The LSCB should aim for completion of an SCR within six months of initiating it. If this is not possible (for example, because of potential prejudice to related court proceedings), every effort should be made while the SCR is in progress to: (i) capture points from the case about improvements needed; and (ii) take corrective action to implement improvements and disseminate learning.

### **Agreeing improvement action**

The LSCB should oversee the process of agreeing with partners what action they need to take in light of the SCR findings, establish timescales for action to be taken, agree success criteria and assess the impact of the actions.

### **Publication of reports**

All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.

### **Final SCR reports should:**

- provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- be suitable for publication without needing to be amended or redacted.

LSCBs should publish, either as part of the SCR report or in a separate document, information about: actions which have already been taken in response to the review findings; the impact these actions have had on improving services; and what more will be done.

When compiling and preparing to publish reports, LSCBs should consider carefully how best to manage the impact of publication on children, family members and others affected by the case. LSCBs must comply with the Data Protection Act 1998 in relation to SCRs, including when compiling or publishing the report, and must comply also with any other restrictions on publication of information, such as court orders. The timing of publication should have due regard to the impact on any ongoing legal proceedings, including any inquest.

LSCBs should send copies of all SCR reports, including any action taken as a result of the findings of the SCR, to Ofsted, DfE and the national panel of independent experts at least seven working days before publication. If an LSCB considers that an SCR report should not be published, it should inform DfE and the national panel. The national panel will provide advice to the LSCB. The LSCB should provide all relevant information to the panel on request, to inform its deliberations. In cases where an LSCB is challenged by the panel to change its original decision about publication, the LSCB should inform Ofsted, DfE and the national panel of their final decision.