Case review procedures

Contents

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For Everyone

1. Introduction

1.1 Child Safeguarding Practice Reviews (England) or equivalent: Child Practice Reviews (CPRs) Wales; Case Management Reviews (CMRs) Northern Ireland; Significant Case Reviews (SCRs) Scotland and Serious Case Reviews (SCRs) Jersey, are the current way in which incidents where a child has died or been seriously injured through neglect or cruelty are reviewed and reported. Case Reviews are tools for learning and making improvements in multi-agency safeguarding and child protection practice[1]. A more detailed explanation of these processes can be found in Appendices 8-13.

1.2 Domestic Homicide Reviews (DHRs) in England and Wales are undertaken where the circumstances in which the death of a person aged 16 or over, has or appears to have, resulted from violence, abuse or neglect by:

- A person to whom they were related or with whom they were or had been in an intimate personal relationship

or

- From the same household, held with a view to identifying the lessons to be learned from the death.

As the DHR process is similar to Child Safeguarding Practice Reviews, the Case Review procedure should be used and followed for DHRs. A more detailed explanation of the DHR process can be found in Appendix 13.

1.3 Other types of reviews that NSPCC may become involved in are: local learning reviews, adult safeguarding and learning reviews and multi-agency public protection arrangement case reviews. Where these arise, the Case Review procedure should be followed.

1.4 NSPCC takes its case review responsibilities seriously as set out by Government in the UK, and will contribute openly and willingly in case review processes. In addition, as an independent charity, NSPCC cannot be confined by the position of Safeguarding Boards and as such it may be necessary to assert our independence in specific cases or circumstances.

1.5 This procedure is closely based on Chapter 4 of *"Working Together to Safeguard Children"* (England 2018); equivalent guidance exists in Wales, Northern Ireland, Scotland and Jersey. Whilst this guidance applies to England, the procedure set out below must be followed by staff working in all jurisdictions, unless specific reference is made to variations for colleagues working in other nations. NB: Refer to appendices for these procedures.

1.6 Multi-agency safeguarding arrangements (England); Local Safeguarding Children Boards (Wales); The Safeguarding Board Northern Ireland; Child Protection Committees (Scotland) and Safeguarding Partnership Board (Jersey) have a duty to make arrangements to work together to safeguard and promote the welfare of all children in a local area. They also have responsibility for implementing case review processes in their respective areas. For this procedure, they will be referred to as Safeguarding Boards.

[1] Case Reviews is used generically to refer to all reviewing processes – England, Wales, Northern Ireland and Scotland

1.7 Safeguarding Boards are required to ensure appropriate representation in case review processes of the professionals and organisations who were involved with the subject and family. Where NSPCC services were provided, the NSPCC Inspection Unit will provide information in writing about the NSPCC's involvement with the child or adult who is the subject of the review. The priority is to ensure that important factors in the case can be identified, arrangements for staff support are in place, appropriate action taken to improve safeguarding arrangements for children, and capture learning for future practice. In addition, any written contribution will have regard to the requirement that reviews in England, Wales, Scotland and Northern Ireland must be published. There is an option of producing a simplified version of the overview report for general publication in Jersey.

1.8 All breaches of these procedures are monitored by the NSPCC Case Review Learning Group. Where breaches occur the Safeguarding Unit must be informed.

1.9 The Chief Executive **and** Safeguarding Unit **must be informed on the same day** of information that relates to:

- In Children's Services - a death or serious abuse or neglect in an open or recently closed case
- In National Services - a death or serious abuse or neglect in a contemporaneous or recent telephone/ online contact

  and any

- Death or serious abuse or neglect likely to trigger a Child Safeguarding Case Review or equivalent, and/or likely to trigger media interest (imminently)
- Obvious or apparent NSPCC/Childline serious systems failure e.g. recording system, or serious performance or conduct breach
- Death or serious incident that is very distressing to the practitioner/manager and to whom the Chief Executive might offer a word of support

This information can be a brief rather than a comprehensive report, with further information to follow if necessary, making a judgement about what needs to be shared. Same day alerts are the priority.

The Safeguarding Unit must be informed via safeguardingboardteam@nspcc.org.uk or by contacting 07920 234267.

2. Record Checks

2.1 This part of the procedure must be followed for internal and external record check requests including:

- All child death notifications and external requests for record checks or agency management reports as part of case review activity
- All serious incidents as described in 1.9
- Requests for NSPCC regional and national media teams to make comment in relation to specific cases or to provide a spokesperson for interview

- Any other request for NSPCC to provide training and consultancy services in relation to a case review
- Requests to Knowledge and Information Services to publish reviews on the external NSPCC website as part of the case review repository

2.2 All notifications or requests for records checks should be submitted by e-mail to the safeguardingboardteam@nspcc.org.uk or via telephone to 07920 234267 - both are monitored by the Safeguarding Quality Assurance Unit. Media teams dealing with out of hours requests are requested to contact 07920 234267 for assistance.

2.3 Checks must not be undertaken at local level by Children's Services or submitted directly to the Helpline. This is to ensure comprehensive checks of Children's Services, Helpline, Childline, Child Trafficking Advice Centre (CTAC) and Participation records are included.

2.4 The Safeguarding Quality Assurance Unit will record all requests for record checks and then undertake a search of all Service, Helpline, Contact Centre and CTAC records. The National Services Information Team will also undertake a search of Childline systems.

2.5 Where a possible match of records is found, all information including the external request will be passed to the Safeguarding Quality Assurance Consultant or in their absence the Head of Inspection and Internal Audit who will review the records and request further information from the safeguarding board/external enquirer as necessary.

2.6 Once it is confirmed that relevant records are found the Safeguarding Quality Assurance Consultant will inform:

- Head of Inspection and Internal Audit
- Chief Executive
- Head of Service (Children's Services, Helpline and Childline) where record relates to that service
- Service Manager/Region/National Head of Services when records relate to Children's Services
- Head of Media.

2.7 Where a positive record check i.e. match has been made relating to service records the Safeguarding Consultant will ensure records are secured.

2.8 Where a request is received for Childline information (e.g. as part of a case review, scoping exercise or case review that is not a serious case review, child practice review or significant case review) a decision to share information must be made in conjunction with the Head of Childline and Safeguarding Quality Assurance Consultant. Where there is a question of confidentiality and a request has been made to comply with sharing information as part of a review process, any request for information about a child should be 'necessary' and 'proportionate' to the reasons for the request. In these circumstances, a decision about whether and what information should be shared will be made on a case by case basis in consultation with the Head of Childline, Legal, Data Protection Manager and Safeguarding Quality Assurance Consultant. In circumstances where agreement cannot be reached, the Head of Child Protection Quality Assurance will have responsibility for the final decision.

3. Recommendations and Learning from Case Reviews

3.1 *The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving* (p81: Working Together 2018). This principle is also reflected in the arrangements in Wales, Northern Ireland, Scotland and Jersey.

3.2 The Case Review Learning group has been established to coordinate and support learning from Case Reviews (e.g. recommendations, findings and learning) on behalf of the NSPCC and reports to the Safeguarding Leads group. Achieving this will support improving and developing the organisations safeguarding arrangements and practices that keep children safe from harm. Using the learning from case review framework, the group will focus on identifying learning for the organisation across all services and nations. These mechanisms will operate collaboratively to ensure corporate dissemination and embedding of learning from case reviews throughout the organisation as applicable.

3.3 The Inspection Unit sign off recommendations and these are monitored by the Audit and Risk Committee. A copy of each action plan should be sent to the Head of Child Protection Quality Assurance. Implementation must include a process for monitoring impact and reviewing outcomes, which is supported by the Case Review Learning group.

3.4 The relevant Director for the directorate in which the incident occurred, is responsible for maintaining a continuous record of all action points arising from case reviews. This ensures that local and national applicable recommendations are implemented through relevant line managers.

For Safeguarding Quality Assurance Unit, Inspection Unit, and Directors

4. NSPCC Contributions to Reviews - Roles and Responsibilities

4.1 The Head of Inspection and Internal Audit is responsible for establishing:

- A timescale for the completion of an individual management review (IMR), chronology or summary report, including review and reporting dates where applicable
- Appropriate workload capacity for the inspector undertaking the work
- Any other support which may be required, including consultancy or administrative
- Process for the involvement of local staff where required to contribute to the review including interviewing, briefing and sharing feedback to those who have contributed when the work is concluded.

4.2 Where the NSPCC have been asked to undertake a preliminary review of records and are subsequently *not* required to provide a written contribution to the review, but in doing so identify issues for learning; the inspection unit may undertake an internal review of service provision, notifying the Head of Child Protection Quality Assurance and relevant directorate Director. This learning will be shared with the Case Review Learning group for further dissemination.

4.3 An individual management review (IMR) is different to and separate from any disciplinary investigation or individual inquiry; although information gathered during the review process may be used to inform such an investigation or inquiry. Disciplinary action may be taken on a concurrent basis while a case review is in progress.

4.4 The aim of the individual management review is to provide information in writing about the NSPCC's involvement with the child who is the subject of the review. It is essential that the management review includes a critical appraisal of NSPCC practice, management and organisational structures. This appraisal should distinguish between compliance with NSPCC standards/procedures and best practice (with supporting evidence). Where the review is historical, a clear distinction should be made between standards and norms of practice at the time and those existing now. Where weaknesses of NSPCC practice, management and/or processes are apparent, legal advice should be sought on the most appropriate wording.

4.5 IMRs should be constructed using the outline format provided by the external Case Review Panel. Those conducting the review may identify other questions or issues which need to be explored. IMRs should address all issues covered in any terms of reference set out by the case review panel or equivalent.

4.6 IMR authors or any other persons engaged in the review process should consider any factors which might lead to an exposure of legal risk (including cases of doubt) e.g. an admission of liability which might lead to a claim for negligence against the NSPCC. Consideration should be given at the outset of the NSPCC contribution to the review and at relevant points in the review process. The NSPCC legal team should be alerted where necessary.

4.7 Responsibilities of the IMR Author:

- Liaise with the nominated service manager at the initial planning stage to discuss their contribution to the IMR plan/process based on their knowledge of relevant service(s)
- Ensure that the IMR process properly reflects local services working arrangements
- Regularly liaise with the Service Manager about review process updates and developments
- Decide with the Head of Region/Nation of Service how any specific actions will be responded to and how the findings of the report will be disseminated to the relevant teams and services.

4.8 The Inspector conducting the management review should talk to relevant NSPCC staff or volunteers. If a staff member or volunteer wishes to be accompanied by a representative for the interview they should discuss and agree this with the Inspector.

4.9 Where a staff member or a volunteer has left the NSPCC, a judgement should be made regarding how important the interview is. Where necessary, efforts should be made to locate and interview the individual concerned and identify how support may be offered to them during the process.

4.10 The directorate Director must identify and if necessary, respond to any immediate staff care needs, ensuring arrangements are made to support and care for staff including if appropriate:

- Compassionate leave
- Counselling by an independent person through the NSPCC Employee Assistance Programme.

The relevant Director must decide whether any further action is required post review in relation to staff care needs.

4.11 Staff and volunteers involved in the case should be allowed a reasonable time away from normal duties to prepare for and contribute to the management review and to comment on the report.

4.12 All staff and volunteers referred to in the IMR have the right to:

- See notes of any interview involving them
- Correct any factual errors.

These processes should not delay completion of the report beyond the agreed timescale.

4.13 The IMR must be completed within a six-week timescale. The Head of Child Protection Quality Assurance will receive two weeks' notice of when final drafts of IMRs and related action plans will be received for review. The Head of Child Protection Quality Assurance is responsible for ensuring these documents are quality assured and meet NSPCC standards and are compliant with relevant external standards set out in Working Together (or equivalent across nations).

4.14 The Head of Child Protection Quality Assurance will ensure that completed and quality assured IMR reports are passed to the relevant Director who is responsible for signing off recommendations together with the associated action plan.

4.15 Any information sent externally in response to a case where there has been NSPCC involvement e.g. an initial scoping report, **must** be sent via the Safeguarding Quality Assurance Unit by secure external CJSM email system or via the respective Safeguarding Board secure system.

4.16 When a management review is submitted, the Safeguarding Board must be notified in writing that the review report is submitted with the understanding that NSPCC retains ownership of it and it is submitted purely for the purposes of the case review and should not to be released/disclosed by the Board to others, without the consent of the NSPCC.

4.17 After the review, the secure status of case records (including the electronic record) must be reviewed. Any action will usually be taken after the IMR has been circulated and after responses have been given by all agencies involved. The decision to remove the secure status of case records must be taken by the Safeguarding Consultant in consultation with the relevant Director. Directors may decide to retain secure status of records based on:

- Matters relating to actual or likely criminal proceedings
- Disciplinary proceedings within the NSPCC
- Matters relating to a Public Enquiry
- Any other issues which require secure retention of records.

5. For Media staff

5.1 Cases involved in a serious case review may prompt a high degree of media interest. The NSPCC must anticipate and prepare for such interest and its response must be flexible and co-ordinated, as far as possible, with other partner agencies involved. The Head of Media should

always be informed by the Safeguarding Quality Assurance Consultant when an IMR or any other similar process is to be carried out.

5.2 The following principles will inform the NSPCC media role in the publication arrangements for case reviews:

- The NSPCC media response should be informed by the *guidance on the use of case review material*
- NSPCC will always seek to be involved in arrangements for joint media responses, but reserves the right to issue independent statements in specific cases or circumstances. The Head of Media will ensure the co-ordination of any national media response.
- The Senior Media Officer will also ensure the co-ordination of national and local media responses and the appointment of appropriate spokespersons

5.3 No media activity relating to cases that may be subject to case reviews should be undertaken without a check of NSPCC records. The process outlined in Section 2 must be followed.

5.4 Information regarding the review should not be made public where this might be:

- In contempt of court, or
- In any other way, be prejudicial to any civil or criminal proceedings, or
- In contravention of the Data Protection Act.

Legal advice should be sought and/or the police consulted as necessary.

6. Disclosure and storage of Case Review Documentation

6.1 If the NSPCC representative on a Safeguarding Board becomes aware of an application to the court in their area requesting a disclosure of case review documentation they should refer directly to the Safeguarding Quality Assurance Unit. The Safeguarding Quality Assurance Consultant should notify the Data Protection team at the earliest opportunity and consult with the NSPCC Legal services before agreeing the release of any documents which will be decided on a case by case basis.

6.2 Records and information pertaining to case reviews must be stored, retained and destroyed as per NSPCC Records Management Policy and Records retention schedule and in line with local Safeguarding Board guidance. When the Case Review process has concluded, the review file, including the relevant (secured) casefile, all relevant reports and related recording (e.g. relating to staff interviews) must be sent to the Records Manager at Weston House. Contact Records@nspcc.org.uk for further information.

6.3 Information should be shared in a secure and safe manner. Further guidance on this is available through Data Protection and Information Security guidance.

For Representatives on Safeguarding Boards

7. Commissioned Case Review Activity

7.1 NSPCC representatives on Safeguarding Boards or equivalents must not chair or author case reviews. This is an organisational position and applies to all nations.

7.2 NSPCC staff sitting on Safeguarding Board Case Review groups or panels, should be aware of their role and responsibilities as defined by the external group and respective statutory guidance and legislation. Regard must be paid to the sensitivity and confidentiality of information held within the group. Where a tension or conflict of interests exists between these requirements and the individual's role within the NSPCC, the line manager and Safeguarding Consultant should be informed with a view to seeking alternative representation or resolution.

8. Child Safeguarding Practice Reviews (England)

8.1 Working Together Statutory guidance states "*Sometimes a child suffers a serious injury or death as a result of child abuse or neglect. Understanding not only what happened but also why things happened as they did can help to improve our response in the future. Understanding the impact that the actions of different organisations and agencies had on the child's life, and on the lives of his or her family, and whether or not different approaches or actions may have resulted in a different outcome, is essential to improve our collective knowledge. It is in this way that we can make good judgments about what might need to change at a local or national level*" (England 2018 p.81).

8.2 The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel (the Panel) and at local level with the safeguarding partners.

8.3 The Panel is responsible for identifying and overseeing the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance. The Panel should also maintain oversight of the system of national and local reviews and how effectively it is operating.

8.4 Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

8.5 The Panel and the safeguarding partners have a shared aim in identifying improvements to practice and protecting children from harm and should maintain an open dialogue on an ongoing basis. This will enable them to share concerns, highlight commonly-recurring areas that may need further investigation (whether leading to a local or national review), and share learning, including from success, that could lead to improvements elsewhere.

8.6 Safeguarding partners should have regard to any guidance which the Panel publishes. Guidance will include the timescales for rapid reviews and for the Panel response.

8.7 Serious child safeguarding cases are those in which:
- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed.

8.8 Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred. Child perpetrators may also be the subject of a review, if the definition of 'serious child safeguarding case' applies.

8.9 For detailed guidance on undertaking Child Safeguarding Practice Reviews please see Chapter 4 Improving Child Protection and Safeguarding Practice, Working Together 2018

9. Child Practice Reviews - Cymru/Wales

9.1 Multi-agency child practice reviews are undertaken in Cymru/Wales under the Statutory guidance for conducting a CPR, Social Services and Well-being (Wales) Act 2014 The London Safeguarding Children Board (LSCB) must undertake a child practice review where within the area of the Board, abuse or neglect of a child is known or suspected and the child has:
- Died; or
- Sustained potentially life-threatening injury; or
- Sustained serious and permanent impairment of health or development.

9.2 There are two types of child protection review: *concise* and *extended;*
- A *concise review* should be undertaken if the child was not on the child protection register or looked after at any point in the six months preceding the incident
- An *extended review* must be undertaken if the child was on the child protection register and/or was a looked after child on any date during the six months preceding the incident that triggered the review.

9.3 The process for carrying out a child practice review. The LSCB child practice review sub-group will make a recommendation to the LSCB chair regarding whether the criteria has been met to undertake a child practice review.

9.4 Each child practice review is managed by a review panel, and an independent reviewer is appointed to work with the Panel. The review engages directly with children and family members, as appropriate, so their perspectives are included. The review involves practitioners and their managers who have been working with the child and family. The review will focus on the practice during the previous 12 months.

9.5 A planned and facilitated practitioner focused learning event is a key element of the review. The event is led by a reviewer independent of the case management and examines current case practice within a limited timeline, using a systems approach.

9.6 A draft, anonymised child practice review report that is succinct and focused on improving practice; and an outline action plan are produced and presented to the LSCB. The LSCB

consider, challenge and contribute to the conclusions of the review and identify the strategic implications for improving practice and systems to be included in the action plan.

9.7 The final report is approved by the LSCB and submitted to the Welsh Government and then published by the LSCB. It must appear on the LSCB website for a minimum of 12 weeks.

9.8 The process for undertaking a child practice review will be completed as soon as possible, but no more than six months from the date of a referral from the LSCB to the review sub-group.

9.9 The action plan is finalised within four weeks of the final report, approved by the LSCB, and submitted to the Welsh Government. The implementation of the action plan is regularly reviewed and progress reported to the LSCB.

9.10 Action plans should lead to improvements in child protection practice and the LSCB needs to ensure they are carefully audited to see whether actions are being carried out and with what effect, and whether they are making a difference. The LSCB must submit a report to the safeguarding team of the Welsh Government on the differences the actions have made to practice.

9.11 For an extended child practice review, the review is undertaken by two reviewers working closely together, who are appointed by the review panel. They will have responsibility for examining how the Statutory duties of all relevant agencies were fulfilled, and report on this to the review panel and the LSCB.

9.12 Alternative Welsh review processes: Where the criteria for a child practice review are not met, the multi-agency professional forum can be used to examine case practice and to provide opportunity for consultation, supervision and reflection.

9.13 Multi-agency professional forums are a continuous LSCB programme of multi-professional facilitated learning events for practitioners and managers. They can be used for case learning events using a systems approach and for disseminating and exploring learning from audits, inspections and reviews.

10. Case Management Reviews - Northern Ireland

10.1 The Safeguarding Board Northern Ireland (SBNI) is responsible for managing and undertaking case management reviews (CMRs).

CMRs are undertaken in the following circumstances where:

(a) A child has died or been significantly harmed;
(b) Any of the following apply:

- Abuse or neglect of this child is known or suspected;
- The child or a sibling of the child is or has been placed on the register maintained by a health and social care trust which lists each child resident in the area of the trust who, following an investigation by the trust is subject to a

plan to safeguard that child from further harm and promote his health and development[2]; or

- The child or sibling of the child is or has been looked after by an authority[3].

(c) The SBNI has concerns about the effectiveness in safeguarding and promoting the welfare of children of any of the person or bodies represented on the safeguarding board;

(d) The SBNI determine that there is significant learning to be gained from the CMR which if applied effectively will lead to substantial improvements in practice, safeguarding and promoting the welfare of children in Northern Ireland.

(e) Where the SBNI has determined that a case demonstrates that any of the person or bodies represented on the board have worked effectively, (individually or in partnership) and that there is outstanding positive learning to be gained from the case which will lead to improved practice in safeguarding and promoting the welfare of children across Northern Ireland.

10.2 CMRs must be undertaken in the circumstances above. Detailed guidance on undertaking CMRs can be found at http://www.safeguardingni.org/resources

10.3 In summary, the Department intends that the CMR process will operate differently from how it did previously. Whilst the emphasis of CMRs was always intended to be on learning, they have in the past been perceived or used as a mechanism to find fault or apportion blame. This was never the objective of the CMR process. There are established mechanisms for holding people and organisations to account when things go wrong. These sit alongside the CMR process which in the future will have a learning outcome focus. Learning from when things go wrong and learning from effective practice for the purpose of strengthening future arrangements for safeguarding children and promoting their welfare.

10.4 To emphasise the learning nature of CMRs, the criteria requiring a CMR to be undertaken has been extended to include cases which demonstrate best practice by any represented body which has potential of leading to improved regional practice.

11. Significant Case Reviews – Scotland.

11.1 The statutory guidance for conducting a significant case review in Scotland is *'National guidance for child protection committees for conducting a significant case review'*(Edinburgh: The Scottish Government 2015).

11.2 In Scotland, Child Protection Committees (CPCs) may be required to conduct a significant case review. The criteria for conducting a review when a child dies and the incident or accumulation of incidents (a case) gives rise to significant/serious concerns about professional and/or service involvement or lack of involvement, and one or more of the following apply:

- Abuse or neglect is known or suspected to be a factor in the child's death;
- The child is on, or has been on; the Child Protection Register (CPR) or a sibling is or was on the CPR. This is regardless of whether or not abuse or neglect is known or suspected to be

[2] Under Article 66 of the Children (Northern Ireland) Order 1995

[3] Within the meaning of Article 25 of the Children (Northern Ireland) Order 1995

a factor in the child's death unless it is absolutely clear to the Child Protection Committee that the child having been on the CPR has no bearing on the case;
- The death is by suicide or accidental death;
- The death is by alleged murder, culpable homicide, reckless conduct, or act of violence;
- At the time of their death, the child was looked after by, or was receiving aftercare, or continuing care from, the local authority.

11.3 When a child has not died, but has sustained significant harm or risk of significant harm as defined in the National Guidance for Child Protection Scotland[4]. In addition to this, the incident or accumulation of incidents (a case) gives rise to serious concerns about professional and/or service involvement or lack of involvement, and the relevant Child Protection Committee determines that there may be learning to be gained through conducting a Significant Case Review.

11.4 Read an overview of the case review process in Scotland.

12. Serious Case Reviews - Jersey

12.1 The Jersey Safeguarding Partnership Board is the multi-disciplinary body charged with advising on child protection issues with particular respect to inter-agency and inter-professional roles. It ensures that robust arrangements are in place for services and professionals to work together effectively to provide accessible, seamless services and prompt appropriate response to child abuse. Within the scope of its delegated roles and tasks, the Jersey Safeguarding Partnership Board agrees and publicises strategies for multi-agency child protection processes and develops policies and procedures based on best practice. It provides training to raise awareness and support best practice.

12.2 The primary purpose of a Serious Case Review (SCR), is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively, to safeguard and promote the welfare of children.

12.3 The purposes of SCRs carried out under this guidance are to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- Improve inter-agency working and better safeguard and promote the welfare of children.

13. Domestic Homicide Reviews

13.1 Domestic Homicide Reviews (DHRs) were introduced to England, Wales and Northern Ireland in April 2011 through the Domestic Violence, Crime and Victims Act (2004). DHRs are

[4] Scottish Government and Campbell, A. (2014) National guidance for child protection in Scotland 2014. Edinburgh: Scottish Government.

undertaken when the circumstances in which the death of a person aged 16 or over (up to 18 years) has, or appears to have, resulted from violence, abuse or neglect by:

- A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- A member of the same household as himself, held with a view to identifying the lessons to be learned from the death.

13.2 Domestic Homicide Reviews are commissioned by Community Safety Partnerships and Statutory guidance under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004). It provides the Community Safety Partnership with a framework for their completion. The statutory guidance for DHRs is consistent with the current framework for undertaking serious case reviews, including asking organisations involved to provide information in writing about its involvement with the child and family, and an overview report compiled by a lead reviewer/author.

14. Table: Case Review Arrangements and Processes in the United Kingdom

Jurisdiction	Safeguarding Boards & Committees	Case Reviews	Management Reviews	Publication
England	Multi-agency Safeguarding Arrangements	Child Safeguarding Practice Review	Depends on review model chosen. May be Individual Management Review or chronology or other	Reviews should be published for 12 months.
Northern Ireland	Safeguarding Board Northern Ireland	Case Management Review (CMR)	Individual Management reviews	Not published
Wales	Local Safeguarding Children Board (LSCB)	Child Practice Review (CPR) - Concise - Extended	Timeline of Significant Events	Published on LSCB website for minimum of 12 weeks
Scotland	Child Protection Committee (CPC)	Significant Case Review (SCR)	Initial Case Review	Report made publicly available if decided (by the local Chief Constable and the Chief Executives of the Health Board and the LA (known as the Chief Officers) that publication is in the public interest
Jersey	Safeguarding Partnership Board	Serious Case Review (SCR)	Individual Management Review	A simplified version of the report may be produced for general Publication