WORCESTERSHIRE SAFEGUARDING CHILDREN BOARD

Working Together to Safeguard Children and Young People

Independent Chair – Diana Fulbrook

Independent Chair
WSCB
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Mr G.U. Williams
HM Coroner
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30th June 2014

Dear Mr Williams,

I am responding to your Regulation 28 Report to Prevent Future Deaths, dated 29 May 2014. Your letter was also addressed to the Chief Executive of Worcestershire County Council, but I assume it was intended for the Local Safeguarding Children Board. Whilst I set out our response below, I should make the point that Worcestershire Safeguarding Children Board is one of 146 Local Safeguarding Children Boards (LSCBs) in England. We follow, but do not set national practice, and I wonder if your report may have been better directed to the Department for Education.

You have requested that Worcestershire Safeguarding Children Board (WSCB) should give consideration to the routine sharing of Individual Management Reviews (IMRs) between agencies, so that a full picture of any identified failings can be obtained in order to prevent future deaths. In response, I will outline the guidance in place at the time the EW Serious Case Review (SCR) was undertaken, that which is now in place and WSCB's response to this.

The EW Serious Case Review was commenced in March 2011 and hence was undertaken in line with the government guidance contained in Working Together to Safeguard Children 2010. Under this guidance a Serious Case Review Panel

was established comprising senior representatives of all the key agencies involved with the child and family. These representatives were independent of the management of the work the respective agencies had undertaken with the family. The Panel received copies of all the IMRs and jointly analysed these with the aim of identifying the key lessons learnt and recommendations for individual agencies and WSCB, which are contained in the Overview Report. Working Together to Safeguard Children has since been substantially revised, and was reissued in 2013. This includes changes to the guidance in respect of

Serious Case Reviews, which is contained in Chapter 4: Learning and improvement framework. The new guidance encourages Local Safeguarding Children Boards to use a wider range of learning models when undertaking SCRs and Case Reviews, including the systems methodology, as recommended by Professor Munro. *(The Munro Review of Child Protection: Final Report: A Child Centred System, published by Department for Education in May 2011.)*

The systems methodology promotes the greater engagement of practitioners and managers in the SCR process and focuses on why those involved acted in a certain way at the time, with the aim of understanding the actions of individual practitioners as well as the functioning of the multi-agency system, and hence learning lessons. Agency Reports are produced by the key agencies involved with the child and family and these are shared with all the practitioners and managers prior to a meeting, or series of meetings. During the process an overview of agencies' involvement can be gained and key findings and lessons to be learnt identified. This approach supports a closer examination of key episodes and decision making points in agencies' work with a family. The final Overview Report is shared and agreed by all those involved in the process prior to presentation to the LSCB.

In response to this guidance a number of models have been developed nationally, including the Social Care Institute for Excellence (SCIE) and the Significant Incident Learning Process (SILP) models. WSCB has already undertaken Case Reviews using both of these models and the feedback to date has been positive. Whilst the process can be challenging for practitioners and managers, they also welcome the opportunity for closer engagement, reflection and learning.

I would suggest that the current government guidance contained in Working Together to Safeguard Children 2013, together with the knowledge that Worcestershire Safeguarding Children Board has fully embraced this guidance, would help to address the issue of the sharing of IMRs which you have raised in the Regulation Report. Government guidance has been developed in the time since EW's death and WSCB has responded positively to this change.

The sharing of IMRs between agencies on the Panel has always been a key element of the SCR process and the more collaborative 'systems approach'

reinforces the importance the Board has always recognised of openness between agencies in order that services can be improved to lessen the likelihood of something similar happening again.

Please do not hesitate to contact me for any further information which you may require.

Yours sincerely

[redacted]

[redacted]
Independent Chair
WSCB