



Serious Cases, Improvement and Learning (SCIL) Sub-Committee

Terms of Reference

1 Introduction

- 1.1 Working Together (2015) states that *Local Safeguarding Children Boards (LSCBs) should maintain a local learning and improvement framework which is shared across local organisations who work with children and families. This framework should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result. Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children. These processes should be transparent, with findings of reviews shared publicly.*
- 1.2 The SCIL Sub-Committee is responsible for fulfilling the WSCB responsibility in relation to this function outlined above and the overseeing of any SCR undertaken by the WSCB.
- 1.3 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.
- 1.4 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.
- 1.5 "Seriously harmed" in the context of paragraph above 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.

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

2 Charing

2.1 The Head of Safeguarding Standards Service for Children's Social Care chairs the SCIL Sub-Committee and provides challenge and oversight of decisions about whether to recommend undertaking a SCR and of those qualitative indicators of standards of practice across the borough.

3 Membership

3.1 Serious Case Review Sub-Committee Membership

Head of Safeguarding Standards Service (Chair)

Assistant Director, Children's Social Care

WSCB Business Manger

Lead for CSE and Missing Children

Head of Workforce, Training & Development

CAIT /Borough Police - Community Safety Unit

Names Nurse for Safeguarding, SW London & St George's Mental Health Trust

Designate Doctor, Wandsworth CCG

Designate Nurse, Wandsworth CCG

Named Nurse, St George's University Hospitals NHS Foundation Trust – Community Services / Acute Services

General Manager, CAMHS

Principal Social Worker

Probation

Education and Inclusion Service

4 Attendance

4.1 The SCIL Sub-Committee will meet on two months intervals and may be recalled for an extraordinary meeting in the event of a serious incident or child death that may meet the criteria for a SCR.

4.2 Those members of SCIL are responsible for attending regularly and this will be reported to WSCB executive via annual report. Any members who fail to attend regularly will be asked to locate a permanent substitute.

5 Scope

5.1 LSCBs will be required to provide a framework for learning and improvement and this will cover the full range of reviews and audits which are aimed at driving improvements to safeguard and promote the welfare of children. Some of these reviews (i.e. Serious Case Reviews and child death reviews) are required under legislation. The final decision on whether to commission an SCR rests with the LSCB Chair.



- 5.2 The SCIL Sub-Committee will be responsible for:
- a. Receiving relevant information from the Child death review - a review of all child deaths up to the age of 18, and a rapid response to each unexpected death of a child;
 - b. Serious Case Review - for every case where abuse or neglect is known or suspected and either:
 - o a child dies; or
 - o 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.
 - c. Management review of a child protection incident which falls below the threshold for an SCR; and
 - d. Review or audit of practice in one or more agencies
 - e. Multi-agency WSCB commissioned audits.
 - f. Review of learning from single agency audits.

6 Principles

- 6.1 The following principles for learning and improvement will be applied by WSCB and partner organisations to all reviews:
- there should be a culture of continuous learning and improvement across the organisations which work together to safeguard and promote the welfare of children – identifying opportunities to draw on what works and promote good practice;
1. the approach taken to reviews must be proportionate according to the scale and level of complexity of the issues being examined;
 2. WSCB and partners will participate fully in SCRs and will make findings available to the public.
 3. WSCB and partners will participate in a multi-agency audit and review programme as their commitment to continuous learning to improve services to children in Wandsworth.
- the impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must be described in WSCB annual report



7 Accountability

- 7.1 The SCIL Sub-Committee is accountable to the Executive Board of WSCB.
- 7.2 The SCIL Sub-Committee must demonstrate to the Monitoring Sub-Committee that improvement is sustained through regular monitoring and follow up so that the findings from these reviews and audits (multi-agency and single agency audits) make a real impact on improving outcomes for children.