Report to:	**Children's Scrutiny Committee**
Date of meeting:	**26 June 2017**
By:	**Reg Hooke, Independent Chair of East Sussex Local Safeguarding Children Board**
Title:	**East Sussex Local Safeguarding Children Board Serious Case Reviews**
Purpose:	**To brief the Committee on the findings and learning from published Serious Case Reviews 2016/17**

RECOMMENDATION:

For the Children's Scrutiny Committee to note the findings and learning from Serious Case Reviews

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1 Background

1.1 The Local Safeguarding Children Board (LSCB) has the statutory responsibility for undertaking and publishing Serious Case Reviews (SCRs).

1.2 This links to the priority outcome of Keeping Vulnerable People Safe in the Council Plan and informs the Pan-Sussex Child Protection and Safeguarding Procedures and council practice and policy.

1.3 The Annual Report and Business Plan of the LSCB are presented to the Children's Services Scrutiny Committee by the Independent Chair. Separate from this, it was agreed in 2014 that the findings and learning from published reviews would be presented to the Committee on an annual basis. This report covers reports published in the year 2016/17.

1.4 The Lead Member for Children and Families is a participating observer on the LSCB.

1.5 The LSCB is independent of the Council and has the responsibility for scrutinising and challenging multi-agency safeguarding practice, therefore the Committee is not tasked to scrutinise the work of the LSCB or the SCRs. SCR reports are submitted to the Department for Education and Ofsted and published on the East Sussex LSCB website.

2 Supporting information

2.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs (under Working Together 2015, DfE). 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.

"Seriously harmed" in the context of 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.

2.1 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.

2.2 If SCRs make recommendations for individual agencies then this leads to an action plan that is scrutinised and signed off by the LSCB. The action identified will be immediately addressed and do not wait for publication to be addressed. Learning is disseminated to relevant practitioners and training is updated to reflect the learning. The LSCB provides Learning from Reviews training that covers the local and national context.

2.3 East Sussex LSCB published 1 SCR in 2016/17. Published in November 2016, this SCR concerns the services provided for a child who is referred to as Child M. Child M was aged 17 in March 2013 when she died as a result of a drug overdose taken while in the company of at least one adult. This was the last in a series of overdoses that Child M took which had resulted in hospital admission and serious health concerns from May 2011 onwards. Child M grew up in Surrey and lived there for the majority of her life. In September 2011, when she was 16 years old, Child M moved to East Sussex.

2.4 The delay in publication was due to the coronial inquest which concluded in June 2016. The LSCB does not publish SCRs until after the conclusion of any criminal or coronial process.

2.5 The attached report provides a brief summary, key learning and summary of recommendations from the SCR on Child M (the full report can be found on the LSCB website).

3. Conclusion and reasons for recommendations

3.1 This report has been provided in order to brief members on key learning and findings from the East Sussex LSCB SCR.

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LOCAL MEMBERS

All electoral divisions are specifically affected by the report.

BACKGROUND DOCUMENTS

LSCB Learning from Reviews June 2017 (attached)

Full SCR reports http://www.eastsussexlscb.org.uk/professionals/serious-case-reviews-2/