Report to:	**Children's Scrutiny Committee**
Date of meeting:	**27 June 2016**
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 2015/16**

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 Children's Scrutiny by the Independent Chair and when it came to the Committee in 2014 it was agreed 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 2015/16.

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 and the 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.

2.3 East Sussex LSCB published 2 SCRs in 2015/16. Published in June 2015 Child K, the death of a young baby and the child's father is currently in prison having been convicted of manslaughter. The Overview Report concludes that this death was neither predictable nor preventable. Published in March 2016 Child P, the death of a 7 year old child who was shot and killed by her father, who subsequently took his own life. The Overview Report concluded that this death could not have been prevented, nor could it have been predicted.

2.4 There is 1 further SCR that has been completed but awaiting completion of the coronial inquest before publication and 1 SCR is currently in progress.

2.5 The report attached at Appendix 1 provides a brief summary, key learning and summary of recommendations from the SCRs on Child K and Child P (the full reports 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 East Sussex LSCB SCRs.

Reg Hooke
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LOCAL MEMBERS

All electoral divisions are specifically affected by the report.

APPENDICES

Appendix 1 - LSCB Learning from Reviews June 2016 (attached)

BACKGROUND DOCUMENTS

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