Learning Points that have arisen from a Quality Assurance Review independently undertaken by the Cheshire West and Chester LSCB regarding notifications to the LSCB for cases to be considered under the criteria for a Serious Case Review.

I. A case should have been considered in 2012, because it met the threshold for an SCR as a child had sustained a life-threatening injury as a result of being shaken. Why staff in 2012 did not report it cannot be determined now. However, the current LSCB have undertaken a range of educational activities to ensure that such an incident would be reported today.

II. The chronologies received from the main agencies involved with the family prior to the incident were insufficiently detailed. This will have been influenced by the passage of time (they were requested in 2016 some four years after the incident). Had they been requested in 2012, there is every likelihood that in addition to the documented records, soft intelligence would have been obtainable from agency frontline practitioners.

III. One of the safeguarding staff the independent author met with advised that they were not accustomed to including detailed information in the chronology, only what they perceived as significant events. They did not appreciate the value of including information that evidenced reasonable case management. Furthermore, if a case was considered and accepted for an SCR, it was not customary for the chronologies to be revisited and made more complete.

IV. To support agencies in delivering consistently good-quality and detailed chronologies, the LSCB is encouraged to review the design of its chronology template. Useful headings and inclusions are:

- What good practice was required, and what policies and procedures were relevant
- Where it is unequivocally demonstrated via the written record that those requirements were met
- Where there are gaps in the records and a determination about procedural compliance cannot be made
- Where information has been obtained from staff to address any gaps in the records so that the initial assessment is as complete as possible in the pre-SCR stage
- Where the chronology reveals either reflective learning points for the team or service involved, and/or potentially more serious breaches in safe practice procedure
- Where a judgement cannot be made because the assessment requires multi-agency consideration at key points of the chronology

V. The LSCB have recognised that the depth and breadth of their considerations, and the evidence base on which they have come to a decision regarding whether to conduct an SCR or peer-learning event, needs to be set out in full for the National Panel so that it can properly assess the case.

Lessons learnt – of national significance

Please see points II, III and IV above, which are all of national as well as local relevance.

May 2018