HERTFORDSHIRE
safeguardingchildren
BOARD

Partnership case review

Guidance for conducting a PCR

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1.0 Introduction

1.1 Introduction

Hertfordshire Safeguarding Children Board through the Serious Case Review sub-group has developed a case review and disseminated learning process called partnership case reviews (PCR).

This process in no way is aimed at replacing Serious Case Reviews (SCR) which remain key to safeguarding and promoting the welfare of children by learning lessons as individuals and collectively as agencies.

PCRs are designed to be used where a case of concern does not meet the SCR criteria as set out in *Working Together to Safeguard Children*, 2010, chapter 8 but it remains that a thorough multi-agency review, drawing out lessons to be learned and good practice, will provide valuable learning and improve outcomes for children.

A PCR involves front line practitioners in a systemic learning review of the case. It is an open dialogue to understand the issues and where appropriate improve practice in a manner where no blame is attached to an individual or agency.

The process by its design provides a more dynamic learning experience both for those involved and the wider partnership through disseminated learning.
The final report and associated action plan is owned and monitored through the SCR sub-group.

2.0 Summary of process

2.1 Which cases meet the criteria for a partnership case review?

- All referrals to the HSCB Serious Case Review sub-group, where the criteria for a serious case review (SCR) are considered not to have been met, are to be considered for a partnership case review.
- Where a referral gives rise to concerns about multi-agency working to safeguard children and lessons need to be learnt then consideration should be given to employing the full PCR process outlined here.
- Where a referral appears to have easily identifiable lessons, or lessons pertaining to just one agency, alternative methods of collating/identifying the lessons will be agreed by the Serious Case Review sub-group.

- In ALL cases where a PCR identifies new information that would suggest the criteria for a serious case review may now be met, then the case should be re-referred to the sub-group for further consideration.

2.2 Aims of the PCR

The PCR process requires one day during which the aims are:

- To agree the facts of the case based on the perceptions of the different agencies represented and the submitted chronologies;
- Identify any relevant lessons to be learnt from the agreed facts of the case
- Use these lessons to inform a three tiered action planning process.

3.0 Planning the PCR

For sections 3.0 – 5.0, please also refer to the Hertfordshire Safeguarding Children Board partnership case review process flowchart at **annex 1**.

3.1 At the SCR sub-group:

- Once a decision has been reached that the case meets the criteria for a PCR, the sub-group should establish the terms of reference**,** including:
  - Who should be invited to participate (i.e. frontline staff and / or their managers)
  - The extent of the chronology and major issues to be included
  - The purpose and goals of the review.

- Identify the PCR facilitation team, including:
  - The PCR facilitator - responsible for facilitating the event (must be familiar with the software)
  - The safeguarding ‘expert’ responsible for ‘chairing’ the PCR
  - The IT co-ordinator responsible for managing the facilitation software.
  - PCR co-ordinator responsible for organising the day.

3.2 The planning meeting

This meeting should take place **within two weeks** of the decision to hold a PCR for the case. The terms of reference will then form the basis for a planning meeting involving the PCR facilitation team. At the planning meeting, the facilitation team will formulate:

- A detailed planning sheet
- A PCR agenda which will be forwarded to all the identified participants.

To support this process all the members of the facilitation team need to work together and be clear about all the aims and objectives of the day.

3.3 Requesting the chronology

At the **same time** as the planning meeting, the agencies involved with the case are also contacted to request a detailed chronology of agency involvement with the child or children and their family between the dates stipulated in the terms of reference.

3.4 Identifying who should attend

Within three weeks of the PCR decision, each agency is also required to identify the frontline practitioners involved and their immediate line managers, and ensure that they are available to attend the PCR. **N.B**. It is very important that all identified participants from the relevant agencies attend in order to give a balanced view.

3.5 Creating the merged chronology

Within six weeks of the PCR decision, all chronologies should be returned to the PCR co-ordinator who will collate them into one unified document for use on the day of the PCR.

3.6 Meeting the family involved

If possible, the safeguarding 'expert' should meet with the child or children and family **within six weeks** of the PCR decision to hear their side of the story. This can provide invaluable insight into the case.

3.7 Practicalities and PCR software

The PCR is usually conducted using net books (small laptops) that utilise software to capture and collate all participants' views and opinions. The software also enables the group to prioritise and rank the learning identified and therefore helps eliminate erroneous learning.

The PCR co-ordinator should ensure that:

- The room used is large enough to facilitate break out discussions (especially the interrogation of the collated chronology which is displayed along one wall) and to accommodate the number of people and laptops required
- There are enough net books for each participant so that they can fully participate in the day.

4.0 The PCR and its structure

Within eight weeks of the PCR decision, the review should have been completed.

The following table is a guide to structuring the PCR:

Session	Title	Process
	Introduction and welcome	'Expert' welcomes the participants. Session includes a short introduction to the technology
	Case review 'expert' to give a case synopsis	'Expert' to give a brief overview of the case and set expectations for the day (review and agree workshop objectives and deliverables). This is designed to encourage discussion and debate and is not the 'definitive' version of events.
S1:	Case chronology	Participants will familiarise themselves with and discuss the chronology, and reveal any additional information.
S2:	Brainstorm 'what happened'	Participants will capture their perspectives on the following three questions: • What information is missing • What worked • What should be improved
	Break	
S3:	Learning theme development	Participants will help sort the data into relevant themes focused on where work needs to be done to ensure the learning revealed is embedded in the case management process.
S4:	Develop learning themes	Pairs/threes to work on the themed data to make sense of the learning opportunities

Session	Title	Process
S5:	Plenary discussion	Session to discuss and 'prioritise' the specific learning opportunities
S6:	Prioritisation	Participants asked to rank the learning opportunities by ▪ Impact (if implemented) and ▪ Ease of implementation
S7:	Recommendations and next steps	Drawing conclusion and recommendations
	Lunch	
	Welcome back.	Facilitator to welcome participants back and review the work of the morning. Summarise the case and the lessons/themes.
S9:	Brainstorm 'what needs to be done'	Participants brainstorm the 'to dos' that will help embed the learning from this case in their individual practice and make suggestions about broader actions.

5.0 Following the PCR

5.1 Summary and recommendations report and action plan

To help facilitate the action planning process, the safeguarding 'expert' will produce a report based on the outcomes of the PCR day, using the format detailed in the PCR summary and recommendations template (see **annex 2**). This should be produced **no later than one week** after the PCR. This report will detail the agreed facts of the case and the agreed lessons to be learnt.

Action planning will be three tiered and undertaken by the SCR sub-group **within two weeks** of the PCR or at the next available SCR sub-group:

- Tier one relates to individual learning and involves PCR participants identifying and owning actions that they will endeavour to pursue in terms of their own safeguarding practice.

- The second and third tiers relate to actions for services both operationally and strategically and are addressed via plans created by the Serious Case Review sub-group.

Any action plans created at tier two and three of the planning process will be monitored by the Serious Case Review sub-group.

The report and action plan should then be summarised for distributing ‘lessons learnt’ for multi-agency and single-agency training purposes **no later than three weeks** after the PCR.

James Townend
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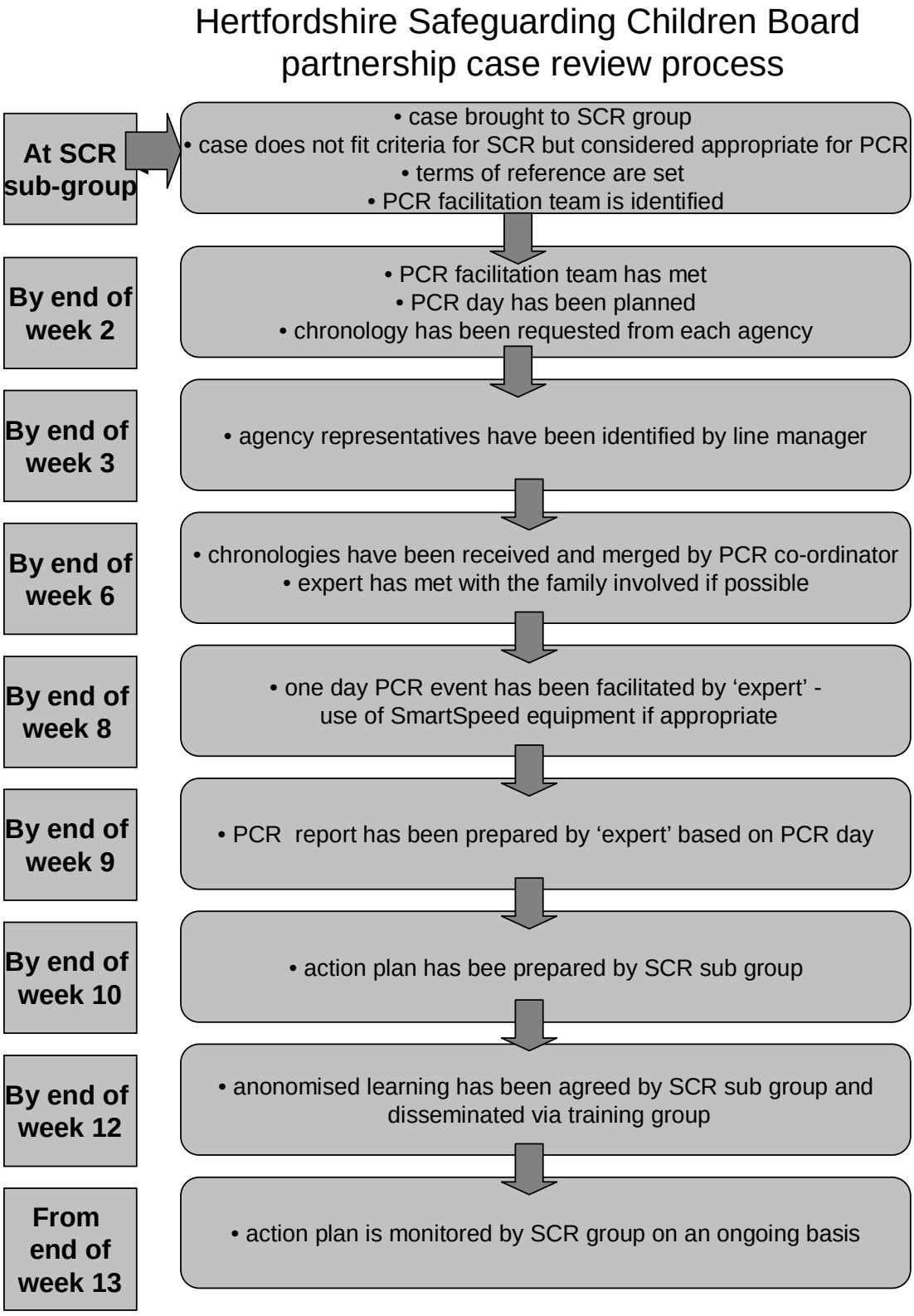
6.0 Annex one: PCR flowchart



Annex two: summary and recommendations template

Partnership case review

Summary and recommendations template

Case reference number:	**Date of review:**
Author:	**Date of publication:**

Introduction

Summarise the circumstances that led to a PCR being undertaken in this case and the process followed by the review.

List the names of those involved in the review including their job titles and employing organisations. Note the parallel processes, where relevant, that are being or have been conducted and how they have interrelated with the processes followed by the review (for example, criminal proceedings etc). Note the extent to which the family (and the child, where he or she has been seriously harmed) have been involved in the review.

The facts/summary of events
Summarise the key facts of the case and the sequence of events. This should be an accurate précis of circumstances of the child and their family and of the chronology of the involvement of the relevant agencies.

Care should however be taken to ensure that the summary is appropriately anonomised and sensitive to the child and family in respect of information that will be available in the public domain. A detailed case history is not required.

Key issues and themes arising from the event
Summarise the key issues or themes arising from the analysis of the PCR, and highlight the key decisions taken in respect of the child and their family and the opportunities for early intervention where they existed. With hindsight could or should different decisions or actions have been taken at the time?

Priorities for learning and change
Describe clearly the conclusions and lessons learned from the review, both for individual agencies and for inter-agency working through the HSCB, ensuring these are in the context of the issues or themes that arose from the case.

Identify examples of good practice as well as being clear where systems should improve.

Recommendations and action plan
Reproduce the recommendations and action plan from the PCR.

The action plan should highlight which recommendations are relevant to which agencies, the agency / agencies responsible for taking forward specific recommendations, how action will be monitored and by whom. It should also set out the progress that has already been made in implementing or completing recommendations and plans to evaluate the impact of these changes.