NHS
Greater Glasgow and Clyde

Child Protection Significant Case Review Guidance (Single Agency)

October 2011

Lead Manager:	Marie Valente, Head of Child Protection Development
Responsible Director:	CHCP/Acute Directors
Approved by:	NHSGGC Child Protection Forum
Date originally approved:	2nd July 2006
Date for Review:	12th October 2014
Replaces previous version: [if applicable]	12th October 2011

1. Introduction

1.1 Clinical incident reporting is an important part of NHSGGC Clinical Governance Risk Management Strategy. It supports an organisation and its members to engage in reflective practice, learning from individual events or trends from recurring events which should support individual practitioners and clinical teams to change practice and the organisation to change its processes to support and enhance patient safety.

1.2 NHSGGC Significant Clinical Incident Policy provides a framework for the management of such events. All child protection reviews will be considered Significant Clinical Incidents and managed in line with the Board framework. This guidance highlights how this applies within the Child Protection Service specifically in relation to single agency significant case reviews. The Significant Clinical Incident Investigation Toolkit contains templates for timelines, reports and actions plans which will be utilised in this process.

2. Levels of Child Protection Review

2.1 There are two processes available – interagency process and single agency process. Circumstances in which an interagency and single agency review should take place are outlined in paragraphs 4 and 5 of this guidance.

3. Definition of a child

3.1 For the purposes of this document a child is a person under the age of 18 (*Interim Guidance for Conducting a Significant Case Review, Scottish Executive).*

4. Circumstances in which an interagency review should take place

4.1 The national *Interim Guidance for Conducting a Significant Case Review, Scottish Executive* indicates that circumstances in which a review should take place are as follows:

4.2 When a child dies and:

- Abuse or neglect is known or suspected to be a factor in the child's death
- The child is or has been on the Child Protection Register or a sibling is or was on the child protection register. This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's death unless it is absolutely clear to the Child Protection Committee that the child having been on the Child Protection Register has no bearing on the case
- The death is by suicide or accidental death
- The death is by alleged murder, culpable homicide, reckless conduct, or act of violence
- The child was looked after by the local authority.

4.3 And in addition to this, the incident or accumulation of incidents gives rise to serious concerns about professional and/or service involvement or lack of involvement.

4.4 When a child has not died but:

- Has sustained significant harm or risk of significant harm, under one or more of the categories of abuse or neglect set out in Protecting Children – *A Shared Responsibility: Guidance for Inter Agency Cooperation.* Bear in mind that cumulative inaction or wrong action may be more difficult to evidence but nevertheless should be considered to the best extent possible.
- The incident or accumulation of incidents gives rise to serious concerns about professional and/or service involvement or lack of involvement.

4.5 Local Child Protection Committees have developed their own guidance and include their own criteria on circumstances in which an interagency review should take place **(Appendix1).**

Child Protection Committees have a key role in progressing multi agency reviews. Single agency reviews are progressed by the individual agency that considers it necessary.

5. Circumstances in which a single agency review should take place

5.1 A single agency review should take place:

a) When a Child Protection Committee decides not to proceed to a full interagency case review but there are single agency issues emerging that require exploration
b) The agency itself decides that this is required.

5.2 An Initial Case Review is when preliminary information is examined by the appropriate SCR sub group of a Child Protection Committee to first determine whether an interagency SCR is merited. The detail and level of the review will depend on the individual case and circumstances. Given that most Child Protection SCR situations will be subject to police investigation these initial case reviews should usually involve record scrutiny. Caution should be applied with regard to directly interviewing staff as this may contaminate police investigation. A template for this initial case review/basic review is attached at Appendix 2.

5.3 The following refers to single agency reviews. Child Protection Committees have produced separate guidance on interagency reviews.

6. Who can request a review?

6.1 Any health care professional can request a review via Child Protection Unit staff (Head of Child Protection Development, Clinical Director, or Child Protection Advisors). All single agency reviews will be requested via NHSGGC Child Protection Unit.

6.2 A review can also be requested by:

- Other agencies
- Child Protection Committees.

6.3 Child Protection Unit Advisors will offer advice and support.

6.4 Any staff member should be aware that where they have concerns they must report it to their line manager who may then request a review.

6.5 The Head of Child Protection Development and Clinical Director must be notified of any concerns that may warrant a single agency review or interagency review. See **Appendix 3** for contact details.

7. The Significant Case Review (Single Agency) Team

7.1 The Head of Primary Care and Community Services (or equivalent in Acute as approved by Director/Clinical governance) (not for the area where the review is being conducted) should lead on the review process and should convene a group to conduct the review. The group should consist of a service manager/team leader from an area other than the one with responsibility for the child in question and a Child Protection Advisor (not the link Advisor for the area where review is being completed).

7.2 It is important that the Review team has members with a broad knowledge of child protection as well as the necessary skills to lead/undertake the reviews.

7.3 Nobody should investigate a situation in which they themselves were directly involved professionally or managerially. This is crucially important.

8. The role of the NHSGGC Child Protection Unit

8.1 The Child Protection Advisor will work alongside the service manager/team leader in the preparation of chronologies, conducting of the interviews, reading of files and any other identified tasks. Discussion will also take place around what supports might be necessary for those workers directly involved with the child. The service manager/team leader and the Child Protection Advisor will compile a draft report, which will be given to the Head of Primary Care and Community Services (or equivalent in Acute as approved by Director/Clinical governance)to approve. The Head of Child Protection Development and Clinical Director will quality assure the report prior to it being distributed to the Child Protection Forum for discussion.

9. Communication within the organisation while the SCR process is underway

9.1 At the point at which an SCR is instigated the Head of Child Protection Development will compile a rapid alert/briefing note for the Board Nurse Director – Board Executive Lead for child protection and key managers with direct responsibility for the case by the next working day (**Appendix 4).** This communication should be restricted to only those managers that need to know. A quarterly briefing note on the progress on the SCR process will be prepared by the Head of Child Protection Development (**Appendix 5).** This communication should be restricted to only those managers that need to know.

10. Reporting format of Child Protection Significant Case Review full report (Single Agency)

10.1 A chronology format is attached at **Appendix 6** and the full report format is attached at **Appendix 7.** The Executive Summary format is attached at **Appendix 8.**

10.2 A sample letter to the Medical Records Manager is attached at **Appendix 9.**

11. Communication of Final Report and Lessons Learned

11.1 Notification to Child Protection Committees

Final reports on single agency and multi agency reviews, having been quality assured as above (section 8) should be forwarded to the Chair of the relevant Child Protection Committee.

11.2 Reporting Arrangements within CH(C) Ps/Acute Division/ Partnerships

A summary report and action plan will be distributed to the NHSGGC Child Protection Forum and Child Protection Operational Groups (Acute) (Partnerships) within agreed timescales. Managers in these groups have responsibility for cascading the learning from SCR's into their service areas via chid protection groups and Acute and Partnership clinical governance forums.

11.3 Feedback to staff

The Head of Primary Care and Community Services (or equivalent in Acute as approved by Director/Clinical governance) will decide upon the arrangements for staff to receive feedback. This can be done in a number of ways: individually, clusters of staff, large group of mixed staff.

12. Confidentiality

12.1 The SCR process is sensitive in terms of information content and staff anxiety. All staff involved, whether directly or indirectly, must protect the integrity of the process and maintain a high level of confidentiality at all times. All information to which Significant Case Review Group Members are subject to is strictly confidential. Review working papers are confidential in nature and should be held securely in a locked cupboard. Staff members should note that all information obtained from the department in connection with this review is held securely in

a locked cupboard. Waste paper must be shredded to ensure that security and confidentiality are not breached, *(NHSGGC Caldecott, Confidentiality and Data Protection Policy, January 2011).*

13. Support for staff

13.1 During the review process staff should feel informed and supported by their managers. Line managers should consider:

- The health and wellbeing of staff involved
- Provision of welfare of counselling support
- Communications with staff and keeping people informed of the process in an open and transparent way
- The need for legal/professional guidance and support
- Time to prepare for interviews and follow up.

14. Monitoring and tracking improvement plans

14.1 Responsibility for actions will be identified in the improvement plan. It is the responsibility of the Head of Child Protection Development to oversee and track progress of these reviews and resulting action plans. A monitoring report to the Child Protection Forum NHSGGC will be provided.

15. Central File

15.1 A central file must be maintained by the CPU which should include, but is not limited to, the following:

- Any staff statements submitted as part of the investigation
- Any reports /documented information submitted to support the investigation
- Final report and action plan.

15.2 All files must be kept for at least 10 years.

16. Key Contributors

16.1 NHSGGC Child Protection Unit
NHSGGC Child Protection Forum
NHSGGC Child Protection Operational Group (Acute)
NHSGGC Child Protection Operational Group (Partnerships)
Members of SCR Working Group (Marie Valente, Jean Herbison, Jack Beattie, Flora Dick, Elaine Clark, Marina Madden' Irene Woods, Alana Gallagher, Angela Reilly, Dorothy Hawthorn, Lesley Nairn, Jacqui McLaughlan, Fiona Andrews, Eleanor Stenhouse, Ellen McGarrigle, Dianne Paterson, Cathie Clark.)
Laura Riach, Clinical Risk Manager, Clinical Governance
Andy Crawford, Head of Clinical Governance

17. Consultation Process

17.1 The Guidance was developed by an SCR Working Group chaired by the Head of Child Protection Development. Consultation was routed through the NHSGGC Child Protection Forum and Operational Groups (Acute) and (Partnerships) who cascaded the draft procedure for comment. Comments were received from:

Elaine Burt – Head of Nursing, RAD
Jamie Houston (Lesley Nairn) – Consultant Paediatrician
Angela Reilly – Glasgow Addiction Partnership
Kerry Milligan – GP Spi, Child Protection Unit

Wendy Mitchell – Senior Community Nurse Manager.

17.2 The draft guidance was also distributed for comment to Child Protection Committee Lead Officers. No comments were received.

18. Bibliography/References

Six Steps to Root Cause Analysis, (2004), Maria Dineen

Protecting Children and Young People: Interim Guidance for Child Protection Committees for Conducting a Significant Case Review, (2007), Scottish Executive.

Significant Case Review (SCR): Developing Best Practice. Report of a Short Life Working Group, (2010), Multi Agency Resource Service (MARS)

Delivering for Children and Young People Partnership Significant Incident Review Protocol, East Dunbartonshire

East Renfrewshire Child Protection Committee, Working Together to Keep Our Children Safe Operational Protocol: Significant Case Review, September 2007

Procedure for Conducting a Significant Case Review in Renfrewshire, Renfrewshire Child Protection Committee

Significant Case Review Operational Protocol, Inverclyde Child Protection Committee, November 2008

Child Protection Committee Significant Incident Review Protocol, West Dunbartonshire Child Protection Committee, October 2008

Significant Case Review Protocol, Glasgow Child Protection Committee, June 2010

Significant Case Review (SCR): Developing Best Practice Report of a Short Life Working Group,

APPENDIX 1

Criteria in which an interagency review should take place Local Child Protection Committees

GLASGOW CITY
CIRCUMSTANCES FOR A REVIEW TO TAKE PLACE
The Committee **should always consider** a review after the death of a child registered on the Child Protection Register. This will apply to deaths by suicide or where abuse or neglect is known or suspected but may not apply to death as result of some other cause e.g. road traffic accident. The Committee **should always consider** whether to undertake a review where a child has suffered a potentially life threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect, and the case gives rise to concerns about the way in which local agencies and services worked together to protect the child. The Committee **may also consider** whether to undertake a case review where there has been a significant inter-agency planning and working in circumstances where new protocols, practices, procedures or guidance may be required and to ensure dissemination of those protocols, practices, procedures or guidance.

INVERCLYDE
CRITERIA FOR IDENTIFYING WHETHER A CASE IS 'SIGNIFICANT'
A significant case may comprise of one significant incident or an accumulation of incidents that gives rise to serious concerns about professional and / or service involvement or lack of involvement. Consideration should be given to the following when making a decision to proceed to an ICR or SCR When a child dies and: • Abuse or neglect is known or suspected to be a factor in the child's death; • The child is on or has been on the Child Protection Register (CPR) or a sibling is or was on the CPR. This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's death unless it is absolutely clear to ICPC that the child having been on the CPR has no bearing on the case; • The death is by suicide or accidental death; • The death is by alleged murder, culpable homicide, reckless conduct, or act of violence • The child was looked after by the local authority **and** in addition to this, the incident or accumulation of incidents **gives rise to serious concerns about professional and / or service involvement or lack of involvement.** When a child has not died but has sustained significant harm or risk of significant harm under one or more of the following categories of abuse or neglect: • Physical injury • Sexual abuse • Emotional abuse • Non organic failure to thrive • Physical neglect **and** In addition to this, the incident or accumulation of incidents **gives rise to serious concerns about professional and / or service involvement or lack of involvement.** Any of the circumstances above could suggest that a SCR may be required. An ICR should first determine whether a SCR is merited. The detail and level of review will depend on the individual case

and circumstances. A review should not be escalated beyond what is proportionate taking account of the severity and complexity of the case.

With regard to death by murder, where the murder is by a stranger, there should be an assumption that the SCR is not appropriate. If during the investigation of the crime any information emerged that might indicate that the parents/carers had failed to protect the child or that the alleged offender was known to protection agencies an SCR should be considered.

Reviewing and reporting the death of a looked after child is a statutory duty under regulation 15 of the Children (Scotland) Act 1995 Regulations and Guidance Scottish Office 1997. The Protocol does not replace that duty. Every effort should be taken to avoid duplication of two processes in these cases, only one of which (the LAAC Report) has a legal basis.

Notwithstanding the terms of paragraphs 2.2.1 or 2.2.2 above, where a specific case does not fall within the criteria, nevertheless ICPC may decide to proceed to a SCR where the incident or accumulation of incidents has clearly triggered significant professional concern.

It is expected that ICPC will consider any request made to them for a review.

For the purpose of this document a 'child' is a person under the age of 18.

For the avoidance of doubt ICPC must bear in mind that often in the circumstances where a review will be necessary criminal proceedings or children's hearing proceedings will be in contemplation and therefore there must be an ongoing dialogue with the police, procurator fiscal and Reporter to determine how fast any review can proceed. The nature of criminal or children's hearing investigations and need to avoid contamination of evidence may mean that in some instances SCR's proceed more slowly than in others.

EAST DUNBARTONSHIRE

CIRCUMSTANCES FOR A REVIEW TO TAKE PLACE.

The DCYPP *should always undertake* a review when a child dies who was registered on the Child Protection Register. This includes death by suicide and death where abuse or neglect is known or suspected to be a factor.

The DCYPP *should always consider whether to undertake* a review where a child has sustained a potentially life threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard the child.

The DCYPP *may also consider whether to undertake* a review where there has been a significant inter-agency planning and working in a case and new protocols, procedures or guidance may be required to ensure dissemination of the good or new practice undertaken.

The DCYPP *may also consider whether to undertake a review* in the event of a child death, or if a child has sustained a significant injury, and the child's name is not on the Child Protection Register.

WEST DUNBARTONSHIRE

CIRCUMSTANCES FOR A REVIEW TO TAKE PLACE.

The Child Protection Committee *should always undertake* a review when a child dies who was registered on the Child Protection Register. This includes death by suicide and death where abuse or neglect is known or suspected to be a factor.

The Child Protection Committee *should always consider whether to undertake* a review where a child has sustained a potentially life threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect, and the case gives rise to concerns about the way in which local professionals and services work together to

safeguard the child.

The Child Protection Committee *may also consider whether to undertake* a review where there has been a significant inter-agency planning and working in a case and new protocols, procedures or guidance may be required to ensure dissemination of the good or new practice undertaken.

The Child Protection Committee *may also consider whether to undertake a review* in the event of a child death, or if a child has sustained a significant injury, and the child's name is not on the Child Protection Register.

RENFREWSHIRE

Criteria for Identifying Whether a Case is Significant

A significant case

A significant case need not comprise of just one significant incident.

Criteria

Consideration should be given to the following when making a decision to proceed to an Initial Case Review (ICR) or SCR

When a child dies and:

- abuse or neglect is known or suspected to be a factor in the child's death;
- The child is, or has been on the Child Protection Register (CPR) or a sibling is or was on the CPR. This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's death unless it is absolutely clear to the CPC that the child having been on the CPR has no bearing on the case;
- the death is by suicide or accidental death;
- the death is by alleged murder, culpable homicide, reckless conduct, or act of violence
- the child was looked after by the local authority

And, in addition to this, the incident or accumulation of incidents (a case) gives rise to serious concerns about professional and / or service involvement or lack of involvement.

When a child has not died but has sustained significant harm or risk of significant harm under one or more of the following categories of abuse or neglect:

- physical injury
- sexual abuse
- emotional abuse
- non organic failure to thrive
- physical neglect

EAST RENFREWSHIRE

CRITERIA FOR IDENTIFYING WHETHER A CASE IS 'SIGNIFICANT'

A significant case need not comprise of just one significant incident

Consideration should be given to the following when making a decision to proceed to an ICR or SCR

When a child dies and:

- abuse or neglect is known or suspected to be a factor in the child's death;
- The child is on or has been on the Child Protection Register (CPR) or a sibling is or was on the CPR. This is regardless of whether or not abuse or neglect is known or suspected to be a factor in

the child's death unless it is absolutely clear to the CPC that the child having been on the CPR has no bearing on the case;

- the death is by suicide or accidental death;
- the death is by alleged murder, culpable homicide, reckless conduct, or act of violence
- the child was looked after by the local authority

When a child has not died but has sustained significant harm or risk of significant harm under one or more of the following categories of abuse or neglect:

- physical injury
- sexual abuse
- emotional abuse
- non organic failure to thrive
- physical neglect **and**

In addition to this, the incident or accumulation of incidents gives rise to serious concerns about [professional and / or service involvement or lack of involvement.

It is expected that CPCs would consider any request made to them for a review, even if the case had been considered at the Initial Case Review to require no further action.

For the purpose of this document a 'child' is a person under the age of 18.

APPENDIX 2

INITIAL CASE REVIEW/BASIC REVIEW REPORT TEMPLATE

Significant Incident Review
Basic Review Report – Confidential

NHS Greater Glasgow and Clyde

Directorate/ Partnership:

Report prepared by:

Report approved date:

Approved by:

Incident Details			
Site		**Ward/dept**	
Date of incident		**Time of incident**	
CHI/ Hospital number		**Patient outcome/ condition**	
DatixWeb reference number: WEB-			
Summary of incident (include actions taken in response)			
Brief summary of events including any relevant background information and events immediately preceding incident and actions taken in response.			
Outline investigation process			
Name and role of members of review team, remit of initial review and brief points on how this was conducted.			
Issues/ Problems identified			
Highlight here any issues identified in the initial review, be clear on their relation to the outcome of the incident and level of action that would be needed to address (i.e. local individual action) Include here any good practice issues identified in the review to encourage sharing of practice.			
Outcome code			
For RCA	Yes☐	No☐	
Comment on decision not to progress to full SCR			
Include reference to outcome code as appropriate i.e. if care appropriately managed			

Action plan completed	**Yes**		**No** (if no include due date for completion or reason)	

APPENDIX 3

KEY CONTACTS

NHSGGC Child Protection Unit

NAME	TITLE	TELEPHONE NUMBER	EMAIL ADDRESS
Marie Valente	Head of Child Protection Development	0141 201 6970	marie.valente@ggc.scot.nhs.uk
Jean Herbison	Clinical Director	0141 201 9355	jean.herbison@ggc.scot.nhs.uk
Kerry Milligan	GP Spi	0141 201 0468	kerrymilligan@nhs.net
Donald Murray	Child Protection Advisor	0141 201 1975	donald.murray@ggc.scot.nhs.uk
Elaine Smith	Child Protection Advisor	0141 232 1974	elaine.smith@ggc.scot.nhs.uk
Rita Brown	Child Protection Advisor	0141 201 0485	rita.brown@ggc.scot.nhs.uk
Carol Bews	Child Protection Advisor	01389 814 344	carol.bews@nhs.net
Fiona Miller	Child Protection Advisor	01475 506 003	fiona.miller2@nhs.net
Phyllis Orenes	Child Protection Advisor	0141 201 0489	Phyllis/Orenes@ggc.scot.nhs.uk
Irene McGugan	Child Protection Advisor	01505 813 119	irene.mcgugan@nhs.net
Dorothy Ramsden	PA to Marie Valente & CP Advisors	0141 201 0642	dorothy.ramsden@ggc.scot.nhs.uk
Patricia McNamee	PA to Jean Herbison & Marie Valente	0141 201 9360	child.protection@ggc.scot.nhs.uk

The Head of Child Protection Development, Child Protection Advisors, GPSpi, Administrative staff and Clinical Director are available daytime hours, Monday – Friday, 9.00 am – 5.00 pm. The Clinical Director is available for clinical advice and intervention 24 hours when on call. Dorothy Ramsden, PA works from 9.00 am – 3.00 pm. Carol Bews and Phyllis Orenes work part time.

Central Legal Office Contacts

NAME	TITLE	TELEPHONE NUMBER	EMAIL ADDRESS
Catriona Robertson	Senior Solicitor	0131 275 7882	Catriona.robertson@nhs.net

APPENDIX 4

SCR RAPID ALERT/BRIEFING NOTE AND DISTRIBUTION LIST

NHS Greater Glasgow and Clyde		Directorate/ Partnership – Rapid Alert/ Briefing Note	
Site		Ward/dept	
Date of incident		Time of incident	
CHI/ Hospital number		Patient outcome/ condition	
Brief patient history			
Summary of incident			
Any immediate action taken			
Any ongoing hazard/ risk			
People contacted following incident			
If applicable:			
RMO/ GP/ Consultant			
Leagal status		Obs status	

Reporting Manager	
Incident Contact (if different from above)	
Date	

Board Nurse Director
General Manager for relevant area of service
Clinical Director for relevant area of service
Clinical Director, Child Protection, CPU
Clinical Director/Lead Consultant, RAH
Head of Child Protection Development, CPU

APPENDIX 5

NHSGGC
Corporate Services

CONFIDENTIAL

NHS
Greater Glasgow and Clyde

QUARTERLY BRIFIFING NOTE ON PROGRESS OF SINGLE AGENCY SCR

CPU, 2nd Floor Medical Records Building
RHSC
Dalnair Street
Glasgow
G3 8SJ

Tel. 0141 201 9360
Fax: 0141 201 0840

INSERT DATE

To INSERT NAMES

cc Ms Rosslyn Crocket, Board Nurse Director
Dr Jean Herbison, Clinical Director in Child Protection, CPU

Re: INSERT DETAILS

APPENDIX 6

CHRONOLOGY FORMAT

CHRONOLOGY FROM ********** SERVICE

DATE	SOURCE	EVENT	ACTION	COMMENT

APPENDIX 7

Significant Incident Review

CONFIDENTIAL REPORT

Full Review Report

NHS
Greater Glasgow and Clyde

Directorate/ Partnership:

Date of Incident:

DatixWeb Reference: WEB-

Place incident occurred:

Report prepared by:

Contents

Overview

The aims of a significant clinical incident review are:

- To establish the background and sequence of events that led up to the incident.
- To identify underlying contributing factors in management and organisational systems.
- To identify lessons learned and develop a list of recommendations that would prevent similar incidents occurring in the future.
- To communicate any findings and recommendations across the organisation including those individuals directly affected or involved.
- To fulfil any mandatory reporting requirements.

It is important to note that whilst acknowledging the professional responsibility and accountability of all staff and departments involved in this incident, it is **NOT** the purpose of this report to apportion blame.

Review Group Membership and Remit

Detail members of review team indicating name and role. Brief outline of remit of investigation. Indicate here if other services/ Directorates involved.

Data Gathering & Process

List steps taken in process of investigation e.g.
Review of incident report forms
Review of individual statements
Review of related documentation and Health Records
Time line construction

Include reference to RCA tools utilised

Summary of the Incident

Background
Provide a brief background to the incident; include relevant information, for example patient clinical history.

Summary of events
Provide a summary of the incident, including events preceding the incident and any immediate action taken in response.

Incident Timeline
Incident timeline should be included, can be added within appendix and referenced.

Findings

Detail within here the findings of the investigation based on analysis of the information, highlighting any areas where issues are identified (good practice to use the cause effect analysis here to allow understanding of the nature of issues for example if a systems error). Also useful here to use headings showing the themes of findings as identified through analysis then detail specifics within each section i.e. documentation, communication.

Conclusions

Detail here conclusions made by team of above issues identified and the impact these had on incident. Should clearly indicate conclusion on the care management in relation to the outcome. Can refer to the causal analysis here and conclude where possible what type of errors have been identified.

Recommendations

Present recommendations to address each of the issues/ conclusions made by team to inform development of actions for improvement.

It is useful here to consider the differing levels of recommendations i.e. do they only impact area of incident or wider and to present information to show this:
Local– those affecting area of incident
Directorate– those which go beyond affected area but within the Directorate
Board– issues which go beyond the Directorate

Appendices

Any RCA tools used should be appended, for example cause effect charts, timelines etc. Also any agreed action plans relating to incident should be appended.

APPENDIX 8

Significant Incident Review

CONFIDENTIAL REPORT

Executive Summary Report

NHS
Greater Glasgow and Clyde

Directorate/ Partnership:

Date of Incident:

DatixWeb Reference: WEB-

Place incident occurred:

Report prepared by:

Contents

Overview

The aims of a significant clinical incident review are:

- To establish the background and sequence of events that led up to the incident.
- To identify underlying contributing factors in management and organisational systems.
- To identify lessons learned and develop a list of recommendations that would prevent similar incidents occurring in the future.
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- To fulfil any mandatory reporting requirements.

It is important to note that whilst acknowledging the professional responsibility and accountability of all staff and departments involved in this incident, it is **NOT** the purpose of this report to apportion blame.

Review Group Membership and Remit

Detail members of review team indicating name and role. Brief outline of remit of investigation. Indicate here if other services/ Directorates involved.

Data Gathering & Process

List steps taken in process of investigation' e.g.
Review of incident report forms
Review of individual statements
Review of related documentation and Health Records
Time line construction

Include reference to RCA tools utilised

Summary of the Incident

Very brief summary of the incident highlighting:

- *Any preceding events*
- *The details of the actual incident*
- *Immediate action taken*
- *Impact on patient*

Conclusions

As in main report, if needed add some detail from the findings to ensure conclusions are clear.

Recommendations

As in main report.

Appendix

Agreed action plans to be included within appendix.

APPENDIX 9

SAMPLE LETTER TO MEDICAL RECORDS MANAGER TO REQUEST MEDICAL RECORDS FOR CHILD PROTECTION SIGNIFICANT CASE REVIEW

Dear **********

Re Child Protection Significant Case Review INSERT NAME AND DATE OF BIRTH OF CHILD

A child protection significant case review on the above named child is in progress and reports have to be completed by INSERT DATE.

Can you please arrange for the medical records of the above child to be made available to INSERT NAME OF CHILD PROTECTION NURSE ADVISOR by INSERT DATE?

Should you require further information please do not hesitate to contact INSERT NAME OF CHILD PROTECTION NURSE ADVISOR.

Yours sincerely

Marie Valente
Head of Child Protection Development
NHSGGC Child Protection Unit