Child Safeguarding Practice Review Panel: practice guidance

April 2019

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Who is this guidance for?

This practice guidance should be read by local safeguarding partners, Local Safeguarding Children Boards (LSCBs) and their partners. It will also be of interest to all senior leaders and frontline practitioners involved in child safeguarding, as well as the relevant inspectorates. The guidance is particularly aimed at those involved in local child safeguarding practice reviews and Serious Case Reviews (SCRs), including reviewers, review panel members and those responsible for decision making around reviews.

About this guidance

This guidance is issued by the Child Safeguarding Practice Review Panel (the Panel) and supersedes that set out in Edward Timpson's letter of 4 July 2018. It should be read alongside the relevant statutory guidance set out in Working Together to Safeguard Children (2018) (Working Together (2018)), Working Together: transitional guidance (2018) and Working Together to Safeguard Children (2015) (Working Together (2015)), parts of which remain in force until September 2020.

As set out in chapter 4 of Working Together (2018), and paragraph 3.2 of Working Together: Transitional guidance (2018), safeguarding partners and LSCBs should have regard to any guidance that the Panel publishes.

Working Together (2018) or (2015), and the transitional arrangements set out the legislative and statutory framework under which the Panel and safeguarding partners and others operate to safeguard and promote the welfare of children. This guidance from the Panel:

- sets out details about the Panel, how it has worked to date since its inception and its practice principles;
- offers some early insights into patterns of activity across England, and commentary on the quality of rapid and SCRs seen to date;
- explores the new opportunities provided by the introduction of rapid reviews, and how this can identify and disseminate new learning quickly.

The guidance starts by introducing the Panel members. The first months of its operation have generated data on the spread, quality and quantity of rapid reviews, the operational and qualitative issues of SCRs, and the complexity and uncertainty of the practice context.

The Panel was established under the Children and Social Work Act 2017 and operates under the relevant legislation and statutory guidance. The Panel has the power to commission reviews of serious child safeguarding cases and to work with local safeguarding partners to improve learning and professional practice arising from such cases. We are very interested in working with safeguarding partners and their partners over time, to realise the benefits of the new safeguarding arrangements set out in the Children and Social Work Act 2017.

The Panel has an important challenge function which it exercises both with local safeguarding partners and with government. From these first months of operation, the Panel is clear that many of the cases are complex and, in some cases, there is no definitive "right" answer to the debates about whether or not an SCR or local child safeguarding practice review should be undertaken, or the circumstances in which it is

not appropriate to publish a final review. As we have seen these can be nuanced and challenging decisions for partners to take. In all instances, the decision as to whether to undertake a learning review should be informed by whether a review would be able to identify improvements to practice.

We have a real opportunity to make a positive improvement to how the child safeguarding system in England operates. Children and families involved in the child safeguarding system and the general public rightly expect there to be improvement through change, and it is our collective responsibility to make this happen. We look forward to developing our relationship with the newly emerging safeguarding partners across the country, so we can make this ambition a reality for children.

Introducing the panel

The Panel became operational in June 2018. Although funded by the Department for Education and accountable to the Secretary of State for Education, we act independently from Government. We are independent from regulatory bodies like Ofsted, the Care Quality Commission and Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services.

The Panel currently comprises eight members, including the Chair. Panel members, except the Chief Social Worker, are appointed through the Centre for Public Appointments procedure. All members are appointed by the Secretary of State for Education for a term of three years. The Chief Social Worker is a standing member of the Panel (ex officio).

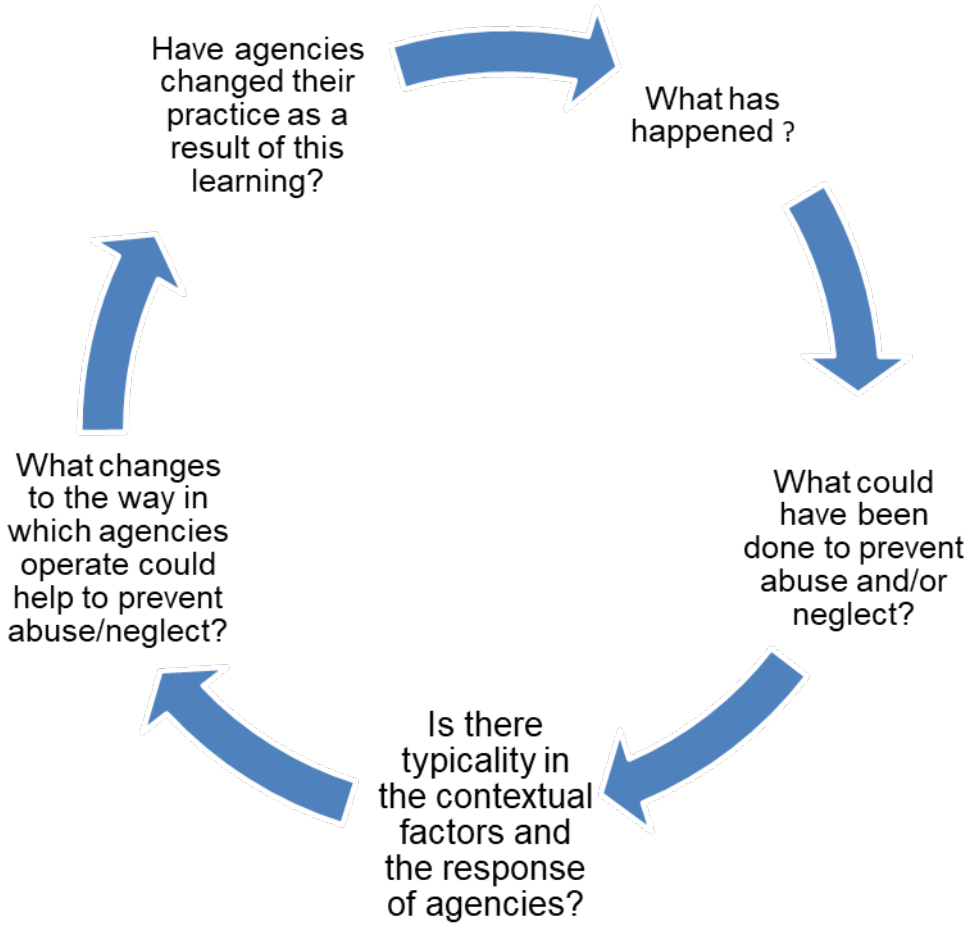
We come with very diverse professional backgrounds and have extensive professional expertise across a range of disciplines. Most of us have long-standing operational experience within the multi-agency network with responsibilities for safeguarding children, including children's social care, police, health and schools. Our individual current roles and expertise are set out here.

Our approach to system learning

We want to use local and national child safeguarding practice reviews to bring about changes that will lead to an improved practice system for children and families and a reduction in child abuse and neglect. We recognise that because of the nature of maltreatment, children may die or be seriously harmed even when practice is exemplary, and often despite the good work that is being done by practitioners. Nevertheless, we recognise that there is always room for learning and improvement, and that there are situations where errors or failings by individuals, or within the system itself which may contribute to or compound the harm suffered by victims of maltreatment.

We have a system in England that is rightly considered one of the most effective in the world in safeguarding vulnerable children. It is a system in which we can have confidence and practitioners within it should feel confident about their skills and expertise. Equally, no system and no practitioner can be perfect and there needs to be sufficient embedded humility to ensure there is the capacity and capability for learning and improvement.

SCRs and local child safeguarding practice reviews should seek to understand both why mistakes were made and, critically, comprehend whether mistakes made on one case frequently happen elsewhere and understand why. This is evidence of system failure. The overall purpose of the child safeguarding practice review arrangements is to explore how practice can be improved more generally through changes to the system as a whole.



It is through this kind of extended analysis that we will understand whether or not a systemic change is required, either at a local or national level. Without it, we risk making unnecessary systemic changes or not addressing the root causes of problems.

Holding organisations and their leaders to account for the quality of services, and individuals to account for not meeting professional standards are essential pre-requisites for public confidence in the national safeguarding system. Regulatory bodies for the professions hold this key role. Reviews are not designed for this purpose and will not be used in this way. Nevertheless, where reviews identify any actual or potential errors or violations, they should ensure that proper lines of accountability are followed to ensure that those responsible are held to account.

We are open at any point to taking advice from safeguarding partners about how we can improve our contribution to safeguarding children and will also provide an annual opportunity for this to be done through structured channels.

The lived experience of children and families plays a crucial role in understanding how we can help improve the safeguarding system. We are considering a range of ways in which the voices of children and young people are best reflected in the national review process.

Our operating principles

We are bound by the Seven Principles of Public Life and operate according to The code of conduct for board members of public bodies. Our Terms of Reference can be found here.

If Panel members have any personal or business interests relating to a specific case or decision which comes before the Panel, they:

- declare this to the Secretariat as soon as they are aware of it;
- absent themselves from any Panel discussion or consideration of the case(s) or decision; and,
- ensure that they make no personal or business use of any insights gained through sight of Panel papers on the case(s) or decision.

How the Panel works

Preparation for Panel meetings

The Panel's role is to identify and oversee the review of serious child safeguarding cases which, in its view, raise issues of complex or national importance. In discharging this function, we work with local safeguarding partners to identify such cases and we maintain oversight of the system of national and local reviews. The Secretariat receives all notifications of serious incidents, completed rapid reviews, any specific queries for the Panel or other correspondence, and pre-publication copies of reviews.

In the week before the Panel meets, each member receives copies of all relevant papers for the following week's meeting. Often the Secretariat or Panel members will have had telephone conversations with specific local safeguarding partners seeking points of clarification, so we are properly prepared, and to assist in making any outstanding decisions.

We want to make decisions as quickly as possible but sometimes we need to discuss matters directly with local safeguarding partners. This avoids getting into protracted correspondence which can rarely substitute for the nuanced discussions needed in some of the more complex cases.

Safeguarding partners should also feel able to contact the Secretariat for points of clarification, although the Secretariat cannot advise about the interpretation of statutory guidance which is for safeguarding partners and statutory agencies to take their own legal advice on.

Panel decisions and records of meetings

All meetings are quorate comprising at least four members of the Panel. In exceptional circumstances, or where agreement cannot be reached by a majority, the decision will rest with the Chair or, in his/her absence, his/her nominated Deputy.

We currently consider approximately 20-40 cases each Panel Meeting. Our ability to manage the volume of casework is helped hugely by the quality of the information given to the Panel. The guidance sets out below what we have found most helpful in the rapid reviews received to date.

Sometimes it is not possible for the Panel to make a decision because we do not have all the information we need, in which case we will write to ask for further information, or where a discussion might be more expedient, a member of the Panel will make arrangements to speak to the relevant safeguarding partners or LSCB Chair.

On occasion when relevant information is missing, the Panel may offer a tentative view prior to making a final decision and, pending receipt of the missing information, about whether or not a SCR or local child safeguarding practice review should be commissioned. This is most likely to happen where the overarching circumstances of the serious incident are clear cut. However, we will not make decisions for safeguarding partners, in any event, even when requested to do so.

Ultimately, the decision to proceed to a SCR or a local child safeguarding practice review is always a local decision, for which local safeguarding partners are accountable.

In a number of cases, there has been a difference of opinion between the Panel and local safeguarding partners about whether or not a SCR or local child safeguarding practice review should be commissioned, and in a few instances, this remains the position after further discussion and information exchange. The Panel does not have the power to require local safeguarding partners to undertake reviews, but should we feel so strongly that a particular case requires scrutiny either as a case in its own right, or as part of a themed review, we may commission a review itself. In these circumstances, the Panel will aim to work collaboratively with the local area, to minimise any inconvenience and to maximise the learning.

We will write letters back to local safeguarding partners or the Chair of the LSCB confirming any decisions we have taken, or to request further information. These letters act as a record of the meeting. We aim to respond promptly with a decision on the majority of cases within 15 working days of receiving the rapid review. Where a conversation is necessary with the LSCB Chair or safeguarding partners, it may take a further few days, but we will always reply as soon as possible.

The role of the Secretariat

We are supported by a Secretariat comprised of civil servants from the Department for Education. The Secretariat is responsible to, and acts on behalf of the Panel. There is a separate team within the Department for Education that supports and advises Ministers on serious child safeguarding cases and monitors the Panel in terms of how it fulfils its responsibilities as set out in legislation and statutory guidance. This is important to maintain the Panel's independence. The Secretariat is also the normal channel for communication between local areas and the Panel, senior civil servants and Ministers, and between the Panel and other internal and external stakeholders. The Secretariat can be contacted at Mailbox.NationalReviewPanel@education.gov.uk

Communications

As a Panel we want to continue to work with you as we identify improvements that should be made to safeguard and promote the welfare of children. This will require an ongoing dialogue through the representative groups for safeguarding partners. We hope to

develop a website which we would like to use creatively to share our thinking as well as sparking debate on key issues. In the meantime the NSPCC continues to hold a valuable repository containing SCRs and other materials which can be found here.

The data we collect

The data we collect helps us to understand the common themes and issues we are seeing consistently. We have been struck for example by the number of cases we have seen where children and families have been subject to court proceedings prior to a serious incident occurring. We are also seeing high numbers of cases involving parents who have previously been in care and adolescents involved in criminal exploitation. LSCBs and safeguarding partnerships will be aware through our communications with them about specific cases and the types of themes we might be interested in exploring nationally.

We also collect a range of other data that allows us to interrogate the system, understand how well processes are working, and measure (to a certain extent) the influence we are having on local decision-making. This includes:

- the number of Serious Incident Notifications we receive;
- the primary cause of death and serious harm in the cases we review;
- how many rapid reviews are received within the 15 working day timescale and our response time to local areas;
- how often we agree or disagree with local area decision making and our ability to influence a change in approach; and,
- how many notifications we receive that do not meet the criteria for a SCR or local child safeguarding practice review.

Our first annual report later this year will present some of this data and we will use it to consider any changes to the way we do things.

Information requests

The Panel may require any person or organisation or agency to provide them, a reviewer or another person or organisation or agency, with specified information. This must be information which enables and assists us to perform our functions, including those related to national child safeguarding practice reviews.

The person or organisation to whom a request is made must comply with such a request and if they do not do so, we may take legal action against them.

Notification of serious incidents

At the time of publication, 133 out of 152 local authorities have notified the Panel of serious incidents. This means we have not heard from 19 local authorities since we became operational on 29 June 2018. However, the Panel is conscious that there will always be some variance between local areas and think that it prudent to give more time for the new system to bed-down before looking at this in more detail.

Is it serious?

The first consideration in deciding whether to make a notification is whether or not the incident is serious, using the definition set out in Working Together (2018). Notifications must always be made if abuse or neglect is a cause of, or a contributory factor to, the serious incident, or where it is suspected. The exception to this is the local authority must notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected.

When deciding whether the level of harm to a child is serious, often this judgement is quite straight forward. For example, because the child has a life-changing and long-term injury or an injury that is clearly life-threatening, for example, requiring resuscitation or intensive care treatment. However, some incidents are not so straight forward and, in these circumstances, a judgement about seriousness is likely to be made. The Panel has noted, for example, how few notifications are received about severe neglect and, for those that are received, how the level of seriousness differs significantly.

The national analyses of SCRs (biennial and triennial reviews) have historically served us very well, allowing us to take a periodic stocktake of serious incidents, and the Department for Education intends to continue to commission this work. In addition to this, the Panel is now in a unique position to pick up quickly any national intelligence about the frequency, nature and patterns of serious incidents across England, and critically to build up a picture about the big system challenges.

We recognise that it is sometimes only through the rapid review that a judgement can be made about the strength of the relationship between the serious incident and abuse and neglect. Where the family is known to children's social care because of a recent incident or current concern about abuse and neglect, and where there has been for example, a suicide or unexplained death, it may well be prudent to notify the event as a serious incident. This is because it may be very unclear at this early stage the extent to which these broader social concerns are relevant to the serious incident in question. The rapid review process can then be used to examine critically the known facts at the time, and the extent to which there is a causal relationship between the abuse or neglect experienced and the incident under review.

In the first few months of our operation, we have seen inconsistencies in what gets reported as a serious incident from different safeguarding partners. The government is

also aware of these discrepancies in reporting and the interpretation of what is a serious child safeguarding case. The Panel will continue to monitor and seek to understand what is behind these differences in our first full year. We will talk to safeguarding partners and others to help us understand these differences.

Rapid reviews

Both LSCBs and safeguarding partners are required to promptly undertake a rapid review on all notified serious incidents. Rapid reviews should assemble the facts of the case as quickly as possible in order to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning.

- **For LSCBs**, the rapid review must conclude with a decision about whether or not a SCR should be commissioned using the criteria set out in Working Together (2015).
- **For safeguarding partners**, the rapid review should conclude with a decision about whether or not a local child safeguarding practice review should be commissioned using the criteria set out in Working Together (2018).

We have seen a great variety of rapid reviews and we are still learning ourselves about the most helpful format. It is unlikely we will wish to prescribe a set format. Whilst the Panel may develop a preference for a particular approach or included content, which we will share with you should this develop, we think it ultimately most important that local safeguarding partners produce that which is most useful to them.

Historically, all learning from serious incidents was established through the SCR process which had become very lengthy and expensive and which was not necessarily matched by the learning gained. Safeguarding partners should also consider, as we move into the new safeguarding arrangements, that rigorous and comprehensive rapid reviews can offer a new mechanism through which the key learning may be identified and disseminated quickly within a matter of weeks**.** A well-conducted rapid review can form the basis of a SCR or local child safeguarding practice review and, in some cases, may avoid the need for an additional lengthy process with limited additional learning.

We do ask as a minimum that the rapid review records:

- whether or not the case in question is being considered against the criteria set out in Working Together (2015) if an LSCB, or Working Together (2018) if local safeguarding partners;
- immediate safeguarding arrangements of any children involved;
- a concise summary of the facts, so far as they can be ascertained, about the serious incident and relevant context; this should give sufficient detail to underpin the analysis against the Working Together criteria, but does not require lengthy detailed chronologies of agency involvement that can obscure the pertinent facts;

- a clear decision as to whether the criteria for a SCR or local child safeguarding practice review have been met and on what grounds, and if not, why not. Clear reasons are required;
- a recommendation on whether or not a national review would be considered necessary, and if so, why. Clear reasons are required;
- any immediate learning already established and plans for their dissemination;
- potential for additional learning;
- if the decision is taken not to proceed with a SCR or local child safeguarding practice review, a summary of why it is thought there is no further learning to be gained;
- which agencies have been involved in the rapid review, explaining any agency omission whose involvement would be usually expected;
- who has been involved in the decision-making process; and,
- relevant identifying details of the child and family.

If the criteria for a SCR are met as set out in Working Together (2015), then there is *no* discretion about whether or not a review should be undertaken. However, consideration should be given as to how the SCR can be undertaken in a way that is proportionate and meaningful. Under Working Together (2018), the criteria for local child safeguarding practice reviews offers greater flexibility for partners to consider how learning is best generated within a new safeguarding arrangement.

Rapid review timescales

We have set a 15 working day timescale for the completion of rapid reviews. However, the quality of those reviews is variable and not all necessary information has always been provided. We are not clear how much of this is to do with the timescale or what other factors are at play. We have heard from a number of areas that meeting the 15 working day timescale is placing pressure on their local systems. We appreciate these points and realise it is a demanding timeframe. Equally, we have had some very effective and comprehensive rapid reviews in the required timescale. We think it premature to extend the timescale at this stage as the new arrangements need to bed-down across the whole country, but will keep it under review.

We recognise that in an effort to meet the 15 working day timescale, safeguarding partners may send in to the Panel a rapid review which has significant information pending, for example, toxicology results, criminal charges, or a long-term prognosis. In most circumstances, though, a rapid review can still be completed, not least because it is the multi-agency working which is the key focus i.e. what happened between agencies *before* the incident. Practice prior to the incident can still be reviewed and supplemented, should new information shed further light on how best agencies can work together in the future.

The quality of serious case reviews

The Wood Review (2016) set out a series of general observations about the quality of SCRs. Many of these are still evident in some of the reviews we are seeing. In particular:

- most are simply too long;
- too much space is given over to the methodology, biographical information about the reviewer(s) and quotations from policy documents;
- lengthy and often extremely detailed chronologies contain 'blow by blow' accounts of agency involvement which risks leading to a report which "fails to look at why events occurred" (Munro, 2011) and obscures key learning points;
- reviews also contain substantial unnecessary personal biographical details relating to family members. At best, this requires subsequent redaction before publication; and,
- there is frequently a significant gap between the incident occurring and the review being published, and the lessons disseminated.

Research suggests that SCRs often reach similar conclusions, repeatedly highlighting issues with interagency working, particularly around information sharing and the quality of recording and analysis of information (see Brandon et al 2010). SCRs are designed to add reflection and learning into local safeguarding systems and that is what the report must focus on, i.e. why do these themes keep recurring and what can be done to address them?

Until all areas have implemented their new safeguarding arrangements and all pre-existing cases have gone through local reviewing systems, SCRs will continue to be commissioned, written and published across the safeguarding system. They will remain part of our system architecture for some time to come. We suggest that LSCBs offer clear guidance to reviewers and ensure that the review process includes the opportunity for reviewers to undertake reflective practice. We urge LSCB Chairs to be rigorous in both the commissioning and sign-off of SCRs, ensuring they meet the standards expected.

In the Panel's opinion, a 'good' report is one that sets down:

- a brief overview of what happened and the key circumstances, background and context of the case. This should be concise but sufficient to understand the context for the learning and recommendations;
- a summary of why relevant decisions by professionals were taken;
- a critique of how agencies worked together and any shortcomings in this;
- whether any shortcomings identified are features of practice in general;
- what would need to be done differently to prevent harm occurring to a child in similar circumstances; and,
- what needs to happen to ensure that agencies learn from this case.

Also, SCRs should:

- have clearly framed questions that the review seeks to answer;
- have an executive summary of no more than 2 A4 pages;
- state clearly the learning points and the steps for professional learning; and,
- be written such that a SCR can be published nationally with minimal redaction.

Serious case reviews and publication

There has been, and continues to be, a great deal of debate about the transparency of the child protection system in England. Whilst it is right that there is transparency through publication, it is also right that we should not place any child at risk of any harm in upholding that principle.

The Panel is frequently asked to consider non-publication of SCRs mostly on the grounds that to publish would in some way jeopardise the safety and/or wellbeing of children. As a Panel we do consider these matters most seriously and balance representations against the presumption in statutory guidance and the Children and Social Work Act 2017 that reviews will be published.

We have suggested on several occasions that the LSCB removes the very intimate and personal detail of a family's life in an effort to reduce the sensitivity of publication. We now have some successful examples of where, following such a re-write, it has been possible to publish the review. Only very exceptionally have we agreed to an SCR not being published locally.

The interface with other statutory processes

The Panel recognises that a serious incident may trigger more than one statutory review process. It remains important for LSCBs and safeguarding partners to organise locally how these can successfully combine whilst still meeting the core purpose of each.

For LSCBs, the statutory requirement to undertake a SCR is fixed, and it will be necessary to commission this, where the criteria are met. There is no discretion as to whether or not it duplicates other statutory processes or the extent to which there may be learning to be gained. Even where statutory processes are brought together, it remains necessary to formally commission and publish a SCR.

Under Working Together (2018) there is greater discretion as to when a local child safeguarding practice review should take place and who does it. This will create greater flexibility in designing a single review mechanism, which still meets a variety of specific statutory obligations.

The Panel is often informed about delays in completing SCRs because of other ongoing proceedings, particularly if criminal proceedings are underway or if there is a coroner's verdict pending for example. **It is not the case that, because these matters are outstanding, a SCR cannot be commissioned, commenced and concluded**, and we will continue to challenge the rationale for such delays. We do, however, recognise that on occasion there are some significant risks to negotiate, for example self-incrimination of interviewees or accusations of witness coaching. To that end, we are in discussions with the Crown Prosecution Service and police with a view to developing guidance about how these risks can best be managed and mitigated.

Commissioning national reviews

The criteria and guidance when deciding whether it is appropriate to commission a national review of a case, or cases, are set out in Working Together (2018).

We have announced our first national review and more details can be found here. An important part of setting up the review process will be a dialogue between the Panel and the local areas affected. This will help make sure the scope and methodology of the review maximises the learning potential and the most efficient of resources, including the time of those involved at a local level.

We have now appointed a pool of potential reviewers who can undertake national reviews, a list of whom can be found here. To enrich and expand the pool, we will continue to run recruitment exercises periodically. However, if we consider there to be no approved reviewers with availability or suitable experience for a particular review, we may also decide to select a person from outside the pool to undertake or support that review.

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