

Second report of the national panel of independent experts on Serious Case Reviews

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Contents

Introduction	3
Notifications	4
Publication	6
Quality	7
Cost	8
Impact	9
Summary	10

National panel of independent experts on Serious Case Reviews

Introduction

1. *Working Together to Safeguard Children 2013*, the Government's guide to inter-agency working published in March 2013, announced that a national panel of independent experts would be established 'to support Local Safeguarding Children Boards (LSCBs) in ensuring that appropriate action is taken to learn from serious incidents in all cases where the statutory criteria are met and to ensure that those lessons are shared through publication of final SCR reports.' The revised version of *Working Together*, published in March 2015, maintains the panel arrangements. This is the panel's second report.
2. Between July 2014 and June 2015, there were approximately 400,000 children in England classed as children in need. Of these approximately 48,000 were subject to a child protection plan¹. During this period there were 326 Serious Incident Notifications (SINs) to Ofsted, and the panel were advised of the initiation of 168 Serious Case Reviews (SCRs). During the same period in 2013-14, there were 281 SINs and the panel was advised of the initiation of 184 SCRs.
3. The panel met for the first time in June 2013, and is made up of four individuals appointed initially for a period of two years. In March 2015, the Minister of State for Children and Families invited all four members to extend their appointment by a further two years. One panel member, Jenni Russell, decided to step down and the panel thanks her for her valuable contribution. The Minister subsequently appointed Alice Miles as a panel member with both child protection policy and media expertise.
4. The panel continues to meet on a monthly basis to consider submissions by LSCBs of notifiable incidents either where (i) there is no intention to initiate an SCR or (ii) there is a proposal that a completed report should not be published. In addition, it has met several LSCB Chairs, and the Association of Independent LSCB Chairs (AILC). The panel welcomed opportunities to discuss its first report at annual conferences of both AILC and the Royal College of Paediatrics and Child Health.
5. The panel thanks the secretariat provided by the Department for Education (DfE) for its continued support.

¹ Figures based on data from <https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2014-to-2015> published on 22 October 2015, which shows there were 391,000 children in need at 31 March 2015, and 49,700 children subject to a child protection plan at the same date.

Notifications

6. In the period July 2014 to June 2015, the panel has been advised of decisions to initiate 168 SCRs. It has considered a further 107 notifiable incidents reported to it where there has been a decision not to initiate an SCR. The panel agreed that, in 86 (80%) of these cases, an appropriate decision had been made. Of the remaining 21 cases, six were subsequently made the subject of an SCR on receipt of the panel's advice, and two are awaiting further information. Of the remaining 13, the panel was satisfied with further explanation or information provided in 10 cases, and in three cases it noted that the LSCB did not accept the panel's advice.

7. For comparison, during the same period in 2013-2014, the panel was advised of the initiation of 184 SCRs. It considered a further 66 notifiable incidents reported to it where there had been a decision not to initiate an SCR, with the panel agreeing in 35 (53%) of these cases that an appropriate decision had been made.

8. Between July 2014 and June 2015, 113 LSCBs contacted the panel. 33 LSCBs did not contact the panel, of which only five have never contacted the panel. In the previous reporting period, 49 LSCBs had not submitted any information to the panel.

9. In its previous report, the panel recommended that DfE and Ofsted should ensure those local authorities which had not submitted a SIN in the previous twelve months, or longer, had had no cause to do so.

10. As a result, DfE undertook a data-matching exercise comparing Office for National Statistics child homicide data with Ofsted SIN data over a period of four years. Two local authorities were identified where a child homicide had taken place in their area which was not reported as a serious incident to Ofsted. They have now submitted notifications. DfE also contacted other local authorities where no notifications had been received: these confirmed that they had not had a serious incident in the previous twelve months.

11. Updated guidance on notifiable incidents was also set out in the amended version of *Working Together*, published in March 2015.

Recommendation one:

The panel recommends that DfE and Ofsted continue to keep Serious Incident Notifications under review and cross reference with other available data to ensure that all serious incidents are notified to national authorities.

12. The quality and quantity of the information received by the panel from LSCBs with each non-initiation or non-publication submission continues to be variable, and is one significant reason why cases are being referred back to LSCBs for further information.

13. In its first report, the panel highlighted issues surrounding the definition of serious harm. In an attempt to address this issue, *Working Together 2015* contains more specific guidance on the definition of serious harm. It is too early to judge the impact of this on the consideration by LSCBs of whether the criteria for an SCR have been met in any given case.

14. There have been several cases where the LSCB Chair's decision not to initiate an SCR has been made before post-mortem results have been fully confirmed. The panel believes such decisions are premature and has submitted these decisions back to the LSCBs for reconsideration once all the essential facts are known.

15. The panel has also continued to challenge unexplained delays. Many cases have delays of several months between an incident occurring and the LSCB Chair's decision about whether or not to initiate an SCR. This makes any review more difficult to conduct effectively, irrespective of whether it is an SCR or not.

16. A few cases have been presented to the panel questioning whether an SCR should be initiated on the basis that the perpetrator, rather than the victim, is a child subject to services provided by the local authority, Board partners or other relevant persons. It is the panel's view that *Working Together* directs that the initiation of an SCR relates to a victim, not a perpetrator.

17. The panel has discussed whether cases where harm (but not serious harm to any one individual) has been caused to a considerable number of young people should be considered to be 'serious harm' sufficient to trigger an SCR. It is the panel's view that this falls outside the scope of 'serious harm' as currently defined in *Working Together 2015*.

Recommendation two:

The panel recommends that Ministers consider whether a future review of *Working Together* should extend the definition of 'serious harm' to include harm that is caused to considerable numbers of young people in a particular LSCB area.

18. Similarly, the panel has considered a small number of cases of still birth involving potential abuse to an unborn child where, under the circumstances, had the child been born alive but subsequently died, an SCR would have been required.

Recommendation three:

The panel recommends that Ministers consider whether a future review of *Working Together* should extend the definition of 'serious harm' to include serious harm to a child in utero where the child is still born.

19. The panel has been contacted on three occasions by individuals not connected with an LSCB to request that it intervenes in specific cases to ask an LSCB to initiate an SCR. The panel's remit is to advise LSCBs based on information provided by them, hence the panel has concluded that it should not normally intervene in relation to such cases brought to it by individuals.

20. In its response to the panel's first report, the AILC stated that:

'The conclusion of the National Panel appears to be that any case where a child has been harmed, regardless of the seriousness or nature of that harm, should result in the commissioning of an SCR.'

This is incorrect. The panel provides advice in line with the criteria set out in *Working Together 2015*. In addition, the panel frequently advises LSCBs, where an SCR is required, to carry out a review that is proportionate to the circumstances being investigated.

Publication

21. In the period July 2014 to June 2015, the panel received copies of 80 completed SCRs prior to publication. In addition, the panel considered 16 cases where a proposal had been made not to publish the final report. The panel agreed with eight decisions not to publish, agreed to anonymous publication on the NSPCC website of two further cases, and to the publication of a summary only in one case. Of the remaining five cases where the panel disagreed with the LSCB decision, two were subsequently published, two were not published and further information is awaited in one case.

22. During the same period in 2013-2014, the panel received 74 completed SCRs prior to publication and an additional seven cases where it had been decided not to publish. Of these, the panel agreed with four² decisions not to publish, agreed to anonymous publication on the NSPCC website of two further cases, and to the publication of a summary only in one case.

23. The panel understands the sensitivity attached to publishing SCRs and is concerned that some SCRs still do not appear to be written in a way that minimises the possible consequences of publication. This may be due in part to the fact that many of the SCRs seen by the panel were initiated prior to *Working Together 2013*. This only serves to highlight the delays which bedevil the system.

² At the time of the panel's first report, all SCRs not being published in full on the LSCB website as required in *Working Together* were classed as non-publication cases, even where a summary was published or a report was published anonymously. This second report sets out in more detail what has taken place where a report is not published in full.

24. Publication is essential to ensure public accountability and spread learning across the system. In accordance with the current requirements of *Working Together*, SCRs must be written with full and unredacted publication in mind. Nonetheless, the panel understands that in exceptional cases there may be a justification for non-publication. In such cases, the panel expects to see expert, independent advice to an LSCB that publication represents a particular and serious threat to specific individuals before it will agree with a decision not to publish in full a completed report, or to publish it in a way which does not identify the LSCB concerned in order to protect the subject child or other vulnerable individuals. There were three such cases in 2013-2014 and a further three in 2014-2015.

25. In the panel's previous report, the panel recommended that DfE should seek to determine what negative effects, if any, the full publication of SCR reports has caused.

26. The panel is not aware of any work undertaken by DfE in this area. AILC has told the panel anecdotally that the publication of SCRs increasingly sees LSCBs challenged in new ways, for instance by professional bodies, threatened litigation from families and victims, or aggressive media attention. However, no clear evidence has yet been submitted to the panel that the publication of a particular SCR has had direct and serious consequences.

Recommendation four:

The panel recommends that DfE and AILC monitor the impact of the publication of SCRs and report to the panel any specific, verifiable instances of direct and serious consequences for individuals as a result of publication.

Quality

27. Compared with a year ago, there are far fewer redactions in SCRs and non-publication is exceptional. The panel welcomes this.

28. The panel remains concerned, however, about the variability of quality in SCRs and the apparent failure of some of them to capture clearly and succinctly what went wrong, and why. Too many are still burdened with detail, whether relevant or not, whilst failing to present clear findings. These findings should include recommendations addressed to senior managers and national bodies as well as those to front line practitioners.

29. The panel is also concerned about delays. Many SCRs still seem to take a very long time to progress to conclusion and publication. Figures from DfE suggest that only 23% of SCRs initiated in 2013/14 have since been published. The panel remains of the view that there are many cases in which a proportionate, focused SCR can and should be capable of being conducted more rapidly and at less cost, with learning thereby

disseminated at a point in time more proximate to the events under consideration. There still appears to be too great an emphasis on the methodology of report writing rather than on the production of a report which succinctly and clearly encapsulates what happened, why and what should be done to prevent a recurrence.

30. Ultimate responsibility for the SCR and its quality lies with the commissioning LSCB. It is the LSCB which will be responsible for taking forward recommendations and promoting learning in their area. Accordingly, the LSCB needs to take a keen interest in the quality of the report writing.

31. In the panel's last report, the panel recommended that DfE should seek to demonstrate what a good SCR looks like.

32. DfE is now funding the Learning into Practice Project (LiPP), whose objectives include improving the quality of SCRs, and commissioning five SCRs centrally in order to develop quality markers and exemplar reports. The project began in March 2015. The panel offered its perspective to the project's leaders at meetings on 8 June 2015 and 12 October 2015. The panel has emphasised to LiPP leaders the importance of producing clear guidance as to the content of a high quality SCR and some first rate examples, rather than replicating sector confusion over what 'quality' looks like in this context.

33. In its last report, the panel recommended that LSCB Chairs should ensure that SCR reviewers they appoint understand the need for any recommendations or findings to be clearly defined and addressed. The panel understands that although a larger pool of trained reviewers is now available to be drawn upon, LSCBs are reluctant to commission untried or untested reviewers. AILC has told the panel it would welcome guidance which LSCBs can use when appointing SCR reviewers in order to improve quality and ensure that consistent standards are applied. DfE has in turn assured the panel that LiPP aims to effect this.

Recommendation five:

The panel remains firmly of the view that, regardless of methodology and specialist sector knowledge, an SCR reviewer must have the ability to produce a clear and succinct account of what happened and why, and what needs to change to prevent it from happening again and it recommends that LSCB chairs appoint reviewers with strong analytical skills.

Cost

34. As stated in its first report, the panel fully appreciates the financial and workload implications for LSCBs of undertaking SCRs. However, its firm view is that the SCR process reflects the seriousness of the cases involved and is key to maintaining public trust in the child protection system. The panel has also repeatedly stated to LSCBs its

view that a *proportionate* approach needs to be adopted to enable the aims of the SCR process to be met without incurring excessive cost or workload.

35. The panel remains convinced that the issue of cost should not be a factor in the decision as to whether or not to initiate an SCR.

36. In its previous report, the panel recommended that DfE should consider the resourcing implications of carrying out SCRs and discuss ways of mitigating this with AILC. DfE has told the panel they have discussed this with AILC and with individual LSCB Chairs. DfE acknowledges that SCRs are amongst the biggest demands made on LSCBs in terms of time, challenge and resource, and, as part of their ongoing policy development in this area, they will continue to explore how the impact on local areas can be mitigated.

Recommendation six:

The panel urges DfE to act to ensure that LSCBs are adequately funded by local partners to support the SCR process; and that AILC in turn receives adequate funding from DfE or member LSCBs.

37. The panel has requested a meeting with Ofsted to understand better how the question of adequate funding of LSCBs is considered in Ofsted inspections.

Impact

38. The point of publishing SCRs is not to punish, but to learn. The panel remains concerned to ensure that the SCR system has the impact intended. It therefore welcomes DfE's agreement with last year's recommendation, to reinstate a regular review of SCRs, including a review of recommendations made and their implementation. Researchers from the University of East Anglia and University of Warwick have now been appointed to conduct a triennial review. The researchers will create a database of the 290 SCRs resulting from notifiable incidents occurring between 1 April 2011 and 31 March 2014. A representative sub-set of about 60 reports will then be reviewed to look for common themes, different report styles used and recommendations made, and a report published by March 2016.

39. A national repository of SCRs managed by NSPCC in partnership with AILC has now been created.

Recommendation seven:

The panel recommends that LSCBs and AILC make full use of the repository to inform local practice improvements; and that DfE monitors any emerging themes from SCRs which suggest the need for national policy responses.

40. Last year the panel recommended that LSCB Chairs should ensure they have a mechanism in place to monitor the implementation of SCR recommendations, including publication in their annual report to show what action has been taken, and by whom. AILC responded that this should be reflected in LSCB annual reports and business plans, and DfE told the panel they would be assessing the impact of this. The panel has requested a meeting with Ofsted to understand better how the implementation of findings from SCRs is also considered in Ofsted inspections.

Summary

41. The panel believes significant and welcome progress has been made in the system surrounding the initiation and publication of SCRs, but that serious barriers to an effective system remain. In particular, the quality of commissioned SCRs is highly variable and publication is obstructed by unnecessary delays.

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