

First annual report

**National panel of independent experts
on serious case reviews**

July 2014

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National panel of independent experts on Serious Case Reviews: first annual report

Introduction

1. *Working Together to Safeguard Children 2013*, the Government's guide to inter-agency working which was 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 panel will report to the Government their views on how the SCR system is working'.

2. *Working Together* stated that the panel's remit would include 'advising LSCBs about:

- application of the SCR criteria;
- appointment of reviewers; and
- publication of SCR reports.'

3. The panel was established in June 2013 and is made up of four individuals, appointed initially for a period of two years. They work in a voluntary capacity. Members have considerable experience in their own fields, but not necessarily directly in the area of child protection.

4. Panel members are as follows:

- **Elizabeth Clarke** is a practising barrister who has specialised in family law for over 20 years, having been called to the Bar in October 1991. She practises from Queen Elizabeth Building, Temple.
- **Nicholas Dann** is Head of International Development at the Air Accidents Investigation Branch, the government body charged with the investigation of accidents and serious incidents to aircraft. He has over 10 years' experience as a senior inspector of air accidents during which time he has investigated a wide range of accidents, both in the UK and overseas.
- **Jenni Russell** is a columnist for The Times who also writes for the Sunday Times and the Evening Standard. She was previously a columnist on The Guardian. She worked as a broadcaster for many years, at Channel 4 News and at the BBC, where she was the editor of The World Tonight on Radio 4. She won the Orwell Prize for political journalism in 2011.
- **Peter Wanless** became Chief Executive of the NSPCC in June 2013, joining from the Big Lottery Fund where he was Chief Executive for five years. Peter was previously a director at the Department for Education, specialising in schools' reform.

5. The panel was appointed by the Secretary of State for Education; however, it considers cases and comes to decisions independently of government. The secretariat is staffed by DfE officials, in order to manage the information on cases to be considered, but the panel is careful to ensure the secretariat maintains its own processes and independence from the DfE. In its first year of operation, the panel has concentrated its main efforts on providing advice to LSCBs on decisions regarding the initiation of SCRs and in cases where LSCBs proposed not to publish an SCR.

6. It has also conducted reviews of completed SCRs but without making comments on specific authors. The decision to confine consideration of completed SCRs to general review without commenting on specific authors was taken at an early stage of the panel's operation. It was considered that this would enable the panel to develop a sense of the general quality of SCRs, with a view to providing feedback on the overall effectiveness of the *Working Together 2013* guidance in this area. The panel has to date chosen not to comment on the appointment of individual reviewers.

7. The panel originally was scheduled to meet every two months but now meets monthly, in order to facilitate more rapid consideration of cases and better support to LSCBs. During the year a number of LSCB chairs have attended panel meetings to discuss issues arising in the SCR process generally and for the panel to receive feedback. The panel has welcomed such meetings, which have proved to be of great value. The panel has also met the Association of Independent LSCB Chairs, the Chief Child and Family Social Worker and DfE Ministers in order to gain further insight into issues influencing the effectiveness of the SCR system. The panel hopes that this first annual report will be useful in clarifying the role and aims of the panel more widely.

Cases considered

8. *Working Together 2013* states that LSCBs should, in respect of incidents notified to them, inform the panel about any decision as to initiation or non-initiation of SCRs. LSCBs should also send a copy of the final SCR report to the panel at least a week prior to publication or inform the panel if they do not intend to publish the SCR.

9. *Working Together 2013* makes clear that the panel's role is advisory. However, if the panel believes that there is a clear statutory breach in respect of an SCR decision, the panel considers it would be obliged to alert DfE and Ofsted to the situation. It has not had cause to do so to date.

10. Since its formation, the panel has been advised of decisions to initiate 184 SCRs. It has considered a further 66 decisions not to initiate an SCR, and agreed in 35 cases (53%) that an appropriate decision had been made, without challenge. Of the remaining 31 cases, five were subsequently made the subject of an SCR on receipt of the panel's advice, whilst the panel accepted the non-initiation decision in respect of 16, after considering further information. Further information is awaited on the remaining 10 cases.

11. The panel has received copies of 74 SCRs prior to publication. In addition, the panel has considered seven cases where it had been decided not to publish.

After consideration, the panel accepted five of the decisions, one case is currently being reconsidered and one has since been published. This means that, on these figures, some 92% of completed SCRs are being published.

12. The panel considers on average about 12 cases each month, in addition to completed SCRs provided for review. On a number of occasions the information provided has not been sufficiently clear or detailed to allow a decision to be made and the matter has had to be referred back to the LSCB concerned.

13. The panel has noted that 49 LSCBs (34%) have not yet been in touch with the panel. Although some of these may legitimately have had nothing to report, the panel takes the view that this is unlikely to be the position with all. The panel will be seeking to clarify the position with regard to those local areas concerned.

Instances where SCRs are not being proposed

14. 'Non-initiation' cases make up by far the largest proportion of the panel's work. As indicated above, in its first year the panel agreed over half of such cases without needing to challenge the initial decision made.

15. The panel has welcomed LSCBs' willingness to engage with it and the positive reaction of most LSCBs' to the panel's advice. This has led to the commissioning of several new SCRs, or has otherwise led to changes in LSCBs' plans.

16. However, there is clearly a deep reluctance in some instances to conduct SCRs and the panel has on occasions found the logic tortuous and considerable intellectual effort expended on finding reasons why an SCR is not required.

17. The panel 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. It is key to ensuring lessons are learned and best practice disseminated whilst maintaining public trust. The panel has repeatedly stated to LSCBs its view that a *proportionate* approach needs to be adopted for the SCR process to enable its aims to be met without excessive cost or workload being incurred.

18. With regard to the main reasons given to the panel for non-initiation, the panel makes the following observations:

- Definition of 'serious harm'

The panel is concerned that some LSCBs are failing to make rational decisions on what constitutes 'serious harm'. LSCBs are sometimes referring to obsolete versions of *Working Together* in the absence of specific guidance in the current version. The panel is strongly of the view that confusion in this area is leading to unjustifiable decisions regarding whether SCR criteria are met. This has included cases where LSCB decisions appear to fail to take account of psychological damage. Some LSCBs also consider serious harm has not been suffered if the victim subsequently recovers from physical injury, regardless of the severity of the initial injury or circumstances.

- Point at which harm has occurred

The panel has seen cases where an LSCB appears to have been overly focused on the immediate cause of death or serious harm, rather than the circumstances leading up to it.

- Failure in inter-agency working

The panel's view is that some LSCBs fail to provide the necessary reassurance that sufficient initial investigation has been conducted to ensure an absence of failure of inter-agency working. In other cases LSCBs will use the obvious failure of one agency to exclude the possibility that others may also have failed, though to a lesser extent.

- Type of review

The panel is bemused by the number of different types of investigation, review or audit that LSCBs hold up as an alternative to carrying out an SCR. To date this has numbered over twenty. The simple fact is that an investigation, regardless of title, should seek to establish the cause of an incident and attempt to prevent its recurrence. SCRs provide a means of accomplishing this which reflects the seriousness of the issues concerned. The panel is not confident that other types of review necessarily investigate failings with sufficient independence, thoroughness and openness, and suspects that on many occasions they are proposed as a way of evading publication.

19. The panel's view is that opportunities to learn from mistakes are being overlooked in the argument over where the SCR initiation line is drawn. It is essential that everyone sees lessons for children's protection (looking backwards and forwards) as the central issue, not the need to abide only by the letter of the law. There should be swift decisions taken on initiating SCRs – which if necessary can be scaled back as evidence emerges – to make sure that learning is not lost.

20. The panel would encourage more LSCBs to consider carrying out a proportionate SCR, even in cases where the statutory criteria are not met, rather than another type of less formal review, so lessons may be understood and shared more widely. Indeed, it is their view that use of a range of investigative tools and techniques to carry out a review in a way which is flexible and relevant to the individual case circumstances may be more appropriate than a more fixed methodology.

21. The panel questions whether the absence of agency engagement with a child should more often trigger consideration of an SCR, as absence of involvement could itself be seen as a failure. This could be increasingly significant where intervention thresholds are rising. The panel has some anxiety about what is accepted as opposed to what it is tolerable for a child to experience by way of neglect or abuse in order for agencies services to become (or stay) involved.

Instances where SCRs are not being published

22. The panel sees relatively few cases where an LSCB is proposing not to publish an SCR report in full, with only seven such cases out of 81 completed SCRs received. The panel accepts that this can be a difficult and challenging area. Its view is that, on balance, LSCBs make sensible decisions about publication, and only withhold publication for justifiable reasons, such as ongoing criminal proceedings, or to protect the welfare of children or other vulnerable family members involved in the case.

23. Where clear evidence has been received which indicates that publication of a full SCR report would not be in the best interests of either the child concerned or other siblings or family members, the panel has sought to ensure that lessons learned from the case are not lost. It has, for example, sought the publication of an anonymised summary report or recommendations published on the LSCB website. On occasion, it has also agreed with an initial decision to delay publication of an SCR pending the outcome of other processes, or to enable appropriate support to be put in place for vulnerable family members.

Quality of SCRs

24. The panel's work is enabling it to develop a sense of the quality of SCRs, and hopes that its feedback a year into its operation will be helpful.

25. In general, the panel's observation is that quality is disturbingly variable, with good reports being outnumbered by the number of reports still failing on key points. The panel welcomes the fact that redaction is now rare, but notes that the reports (particularly those initiated before *Working Together 2013*) often include details which are not relevant to learning, and which can also sometimes make open publication more difficult. It hopes that the situation will improve, as an increasing number of reports being published will have been initiated after *Working Together 2013* was introduced.

26. The fundamental aims of an SCR should be to find out what went wrong in the care of a child, when and why it did so, and what can be done to minimise the chance of the same mistakes being repeated. The panel's view is that far too many SCRs fail to do this effectively.

27. The key problems seen to date include:

- Reports which include irrelevant detail, jargon and acronyms which make it difficult to discern the key events in the narrative. Such reports are unlikely to be widely read or understood, thus failing to meet one of the key objectives of an SCR.
- Reports that repeatedly list what happened without ever stopping to ask why. Why were key decisions made? Why were critical observations missed or simply ignored? In short, why did circumstances exist which caused sometimes terrible detriment to one or more children?
- Reports that fail to look at human motivation and at the crucial roles played

by fear, exhaustion, overwork, timidity, wilful blindness and over-optimism are unlikely to determine the root causes of critical decisions.

- Reports that fail to centre on the child or even address the child's perspective.
- Recommendations which are not clear, focused or addressed to specific individuals or organisations.

28. The panel has reflected on the features it would expect to see in an effective SCR, and has concluded that these would include:

- A sharp focus on what caused something to happen and how it can be prevented from happening again.
- A concise account of critical points in the management of a case (rather than a lengthy chronology of undifferentiated events).
- A detailed analysis of what went wrong and why, including individual errors and system failures.
- Clear learning points and recommendations that are addressed to named people or organisations locally and nationally, including adult services where appropriate. Measures should be included to follow up and see whether these recommendations have been accepted and implemented.
- A focus on what the lessons should be for the services concerned, rather than giving a blow-by-blow account of what happened to a child.
- Proportionate to the case being considered when applying the points above. This is far more important than a blind adherence to a specific methodology. LSCBs should be looking at a 'sliding scale' of SCRs, from those which result in very quick outcomes and a short report, to those which by the nature of the incident require a greater level of investigation.
- Prepared to highlight relevant failings and good practice and policy at all levels, not just those at the lower levels.

Recommendations for improving SCR quality and enhancing learning

29. The panel is keen to ensure that lessons are learned, but does not have confidence that many current SCRs lend themselves to such learning. We therefore make the following recommendations:

- DfE should instigate in the next 12 months a review of SCRs produced under *Working Together 2013* guidance, to judge how well they are measuring up to the points above, and publish the findings. In the light of these it should consider whether the training for SCR authors which it funded has been effective.

- DfE should seek to demonstrate what a good SCR looks like and make this available.
- DfE and Ofsted should ensure those local areas which have not submitted a serious incident notification in the last twelve months, or longer, have had no cause to do so.
- The panel believes that the issue of cost should not be a factor in the decision as to whether or not to initiate an SCR. DfE should consider the resourcing implications of carrying out SCRs and discuss ways of mitigating this with the Association of Independent LSCB Chairs
- DfE should seek to determine what negative effects, if any, the full publication of SCR reports has caused
- DfE should take responsibility for considering how a repository of past reports could become a more active resource for learning, and what role it might play in ensuring the existence of such a centralised resource.
- DfE should consider reinstating the SCR biennial reviews, including a review of recommendations made and their implementation, as a useful facility for reviewing national trends in SCRs.
- LSCB Chairs should ensure SCR authors appointed understand the need for any recommendations or findings made to be clearly defined and addressed.
- LSCB Chairs should each ensure they have a mechanism in place to monitor the implementation of SCR recommendations. This should include publication in their annual report to show clearly what action has been taken, and by whom, in respect of SCR recommendations made in the relevant period.

Responses to these recommendations will be published in our next annual report.

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Reference: DFE-00531-2014