Guidance on the process for undertaking North Tyneside Safeguarding Children Partnership Local Child Safeguarding Practice Reviews

Introduction

This guidance is aimed at those involved in undertaking or contributing to NTSCP's Local Child Safeguarding Practice Reviews (LCSPRs) and clarifies the process for undertaking the reviews.

The guidance is based on legislation and guidance outlined in appendix 1. It should be read in conjunction with NTSCP CRG's Terms of Reference, and the Guidance on the Process for Undertaking North Tyneside Safeguarding Children Partnership's Rapid Reviews.

Purpose of LSCPR

- Good practice LCSPRs identify new learning that is not yet available in local safeguarding systems, or they tackle perennial problems that need further or perhaps different attention. A LCSPR does not automatically explore learning from a RR in more detail although partners may decide to initiate an LCSPR for this reason.
- If a child has been notified and the RR subsequently identifies that the notification criteria is no longer met (for example, there is no evidence of abuse or neglect, or the harm suffered was deemed not to be serious), the safeguarding partners may nevertheless decide to carry out an LCSPR if they deem that there is still potential for further learning and a clear rationale for doing so.

Scope / Time period reviewed

The time period covered should reflect any potential learning likely to be achieved. It should be short and as recent as possible. Including historic time periods which have seen changes in practice rarely provide significant learning however this should be balanced with what could be gained in respect of early interventions which may have been missed. In child exploitation cases it is important to consider the child's early life and scrutinise what was/could have been done to divert from the pathway to further abuse and suffering.

Focus of the review

The key lines of enquiry should evolve during the RR and will be formally confirmed and identified within the terms of reference. They should also be set out within the contract drawn together for the commissioned author.

Engaging family members and children

A genogram should be compiled which will help identify which family members should contribute to the review. Plans to engage with family members need to consider any ongoing parallel proceedings.

Parallel investigations

Cases may at times be subject to parallel investigations. These could be criminal or coronial investigations, professional body disciplinary processes, agency investigations or another type of review (e.g.: DHR; SAR; SI). LCSPR's should go ahead unless there are clear reasons not to. In the case of criminal proceedings, the police will lead on progression and publication of the case. Under Working Together 2018, parallel investigations give the flexibility to reduce duplications and should be considered at the scoping stage.

Timescales
In all cases learning should be identified and acted upon as soon as possible. Agencies must not wait for report publication as reviews will vary in breadth and complexity and thus the time taken to complete may vary.

All LCSPRs should be completed no later than six months from the date of the decision to initiate a review.

Approach
Working Together 2018, provides guidance on commissioning a reviewer or reviewers for an LCSPR. The key consideration is whether the reviewer has the appropriate knowledge and expertise of the child safeguarding system to undertake the review. The reviewer should be able to take a critical and authoritative stance to identifying multi-agency learning. To that end the reviewer should have no real or perceived conflict(s) of interest – i.e., be independent of the case.

Safeguarding partnerships may consider using their own capacity to undertake LCSPRs, as appropriate, provided the person has suitable skills in applying a systems approach to undertake reviews as outlined in Working Together 2018.

Different methodologies and approaches to review are supported and encouraged by the national Panel; however, any further review of a case should be referred to as an LCSPR and should meet the requirements of an LCSPR, including the appropriate involvement of practitioners and families **and the expectation that the report will be published within six months.**

Any decision to undertake a further review of the case after the RR must be conducted as an LCSPR.

This is different to the dissemination of learning arising from a Rapid Review. Where a RR has identified important learning, such that further review of the case is not needed, then consideration should be given to how that learning is disseminated, for example through practitioner learning events or practice briefings; such approaches do not require further review of the case and should not be referred to as review.

A methodology should set out the principles and approach to learning and the methods and tools used to answer the agreed aims and questions.
The methodology should be clear and should describe what was done and how.

Whatever methodology is used, every effort should be taken to **ensure the review gets to the 'why' behind events,** not just the how and the what.

The scope, aims, and terms of reference of the LCSPR should be determined at the start and should be specified clearly in the final report. They should stem from the learning identified in the RR. While undertaking an LCSPR, alternative lines of enquiry or methods might be required, and any amendments should be reflected in the final report.

The LCSPR should start with the key lines of enquiry, questions the review is seeking to answer, and provide evidence and analysis of what the scope and focus of the review will be.

Key lines of enquiry should be few in number (no more than 3 or 4 key questions) and focused on the most important issues for learning. This should be accompanied by a concise summary of the

circumstances and background of the case to lend appropriate context to the reflection and learning of the LCSPR that will follow.

As stipulated in Working Together 2018, all LSCPRs should reflect the child's perspective and the family context. This does not require a descriptive account of all events; the aim is to provide appropriate and meaningful context, sufficient to illuminate the major themes arising from the case.

Key practice episodes can be used to analyse significant events in the chronology and to focus on the role of agencies at these times. Key lines of enquiry can also help to determine questions for agencies and families and can help structure conversations, so that valuable insight is extracted.

Structure and prompts can help get to the core of the practice issues, but conversations should also allow for unstructured contributions and reflection.

The lived experience of a child and where possible and appropriate, their voice, should be dominant throughout a review. LCSPRs should specifically consider these aspects in the analysis of the circumstances of the case, the appraisal of practice, and in the methods applied to the review.

It is imperative that an LCSPR considers the characteristics of a child's identity – such as race, ethnicity, gender, disability. It is important than an LCSPR discusses if and to what extent the characteristics and cultural background of a child and/or family may have impacted professional decision making. Racial, ethnic, and cultural issues are pivotal factors and should be given proper weight when exploring the reality of children's lives in LCSPRs.

A LCSPR should not necessarily be limited to reviewing the specifics of one family and a specific incident but be used to also explore broader aspects of practice, to ascertain whether there are systemic practice issues to be addressed. Study of the particular incident creates the opportunity to study the whole system, both what is working well and what is not, looking at the underlying issues that are influencing practice more generally.

LCSPRs should **not** be written in the style and approach of 'old style' Serious Case Reviews (SCRs) which often included overly long chronologies and did not engage in sufficient depth with system problems, nor explore **why** issues and practice problems may have occurred and what therefore needs to change as a result.

A LCSPR can benefit from bringing in wider relevant evidence related to the case. For example: the context of the local area, data and analysis relating to agencies and services, national or international evidence and learning from other LCSPRs and/or national reviews.

Where there are large numbers of professionals involved in an incident from a range of agencies their involvement should be carefully summarised and focus on key practice episodes to avoid overly long LCSPR chronologies.

Human error, where it is identified, should be a starting point for exploring any deeper systemic issues, and not the conclusion of the review. Asking, why did the person act in the way they did and what was the environment and context in which they were operating, while avoiding an over-focus on what happened is more likely to lead to effective learning and recommendations.

Intersectionality

Intersectionality is the interconnected relationship of social categorisations such as race, gender, and sexual orientation together with individual vulnerability and adversities suffered by the individual. It is important to consider the potential to learn from issues of 'intersectionality' at each stage of the process – particularly when considering the usefulness of an LCSPR.

This is because some children feature more (or less) in the statistics, for example black boys and increased incidents of serious youth violence in London. Racism, bias, stereotyping, or cultural misunderstanding operate at the individual, institutional and societal level, both consciously and unconsciously – which in turn may result in some children being more likely to come to the attention of child protection services, while others less likely to receive the right service. Equity is an important consideration for services, not only in the individual actions we take but also in the process of our decision making.

The independent author will be agreed and appointed by the Safeguarding partners. The timescale, terms of reference and agreed payment amount for the review will be included in a contract written for the successful author. The Safeguarding partners may wish to appoint an Independent Chair who will oversee the meetings of the review team and provide an independent view on the final report.

Review Team

The review team will be the core members of the case review group, any extra subject matter experts when appropriate and representatives from organisations involved with the family.

In line with national Panel guidance, a representative from a local specialist domestic abuse service will also be asked to participate in every RR where domestic abuse is identified, irrespective of whether the abuse is perceived to be current or historic.

The review team are responsible for quality assuring the information from each agency and ensuring that there is enough analysis and insight into practice, processes, and systems. The review team can make the decision to request more information from agencies.

Practitioner events

Practitioner events may be requested by the review author and are an opportunity to have reflective conversations with the key people involved with the child and family. The review author can gain first hand insight into the case by speaking with those directly involved.

Looking at records only tells part of the story of the family's journey through services, hearing professionals' accounts can add a richness to the knowledge gained from reading. These meetings should be positive events where front-line staff (and their managers if the member of staff feels it is necessary) feel supported to talk freely. The review author will use these meetings as an opportunity to hear about the lived experience of the child, analyse why events happened and if 'systems' have influenced the outcomes.

Individual interviews

Individual interviews may take place at the discretion of the independent review author. Some practitioners may be asked to meet with the review author outside of the practitioner events. The expectation is that the review author will provide notes to the individual interviewed to give them an opportunity to correct any misunderstandings or inaccuracies.

The Final report

The report should:

- Contain enough information to provide a clear context for the learning and recommendations and to reflect the perspective of the child and the family, and the views of practitioners.
- Focus on analysis of both practice, systems, and leadership issues
- Clearly identify learning arising from the review
- Include how the impact of any recommendation will be measured.
- Include clear and relevant recommendations linked to action plans that are specific, achievable, and meaningful so it is clear who will take responsibility for their implementation, how, and in what timeframe
- Include recommendations that are few in number and focused on improving practice, rather than simply increasing bureaucracy with more procedures and rules, monitoring and control
- Avoid making recommendations that are vague and general, repeating what should be standard practice, or that seek assurance around issues that should have been covered in the review itself
- Identify whether any of the issues identified in an LCSPR resonate more widely and therefore should be disseminated across the system to support effective local practice
- Consider issues that highlight the conditions in which practice takes place
- Establish at the outset who should see the report, when and how
- Include support for family at the time of meeting and after seeing the report. The process of reading the report needs to meet the needs of families, allowing time in advance of publication to ensure they are aware of the findings and recommendations
- Be signed off by the three safeguarding partners
- **Be completed and published within six months of the agreed decision to undertake an LCSPR. Any likely delays beyond six months should be discussed with the Panel.**

The review team will appraise draft versions of the report and agree accuracy and quality. The report content will be measured against the original terms of reference or key lines of enquiry.

The formal recommendations may be agreed by the review author and the review team, or the partnership may convene a group to develop the learning into recommendations. The formal recommendations will be agreed by the statutory safeguarding partners before the LSCPR report is signed off.

Publication

The fact that an individual or family might be identified is not, in and of itself, a reason not to publish. It is important that relevant steps are taken to anonymise the case and to protect personal and sensitive information. However, the national Panel acknowledges that in most cases, a determined investigator might be able to identify the case, no matter how thoroughly it has been anonymised. What is important is that the review should not contain information that could be harmful to any individual if made public. Since the purpose of the review is to identify and learn lessons to improve practice, the focus of the review should be kept on learning those lessons, with sufficient context to enable the lessons to be meaningful but avoid unnecessary sensitive information.

Working Together 2018 states that:

"*Safeguarding partners must send a copy of the full report to the Panel and to the Secretary of State no later than seven working days before the date of publication*".

However, this does not always align with the fortnightly cycle of Panel meetings. This is particularly pertinent to those reviews which are likely to attract public and/or media interest and also where national recommendations have been made or recommendations about the Panel.

Therefore, in the circumstances outlined above, NT CRG will ensure early discussion with the national Panel so that the implications of the proposed recommendations can be considered.

Media planning will commence once publication is imminent. Statutory partners will liaise with communication/media teams and agree what information will be released should there be media interest.

Recommendations and learning

The case review subgroup is responsible for converting the recommendations into action plans. Agencies represented are responsible for:

- Disseminating the learning within their own agency
- Providing evidence that actions have been completed
- Providing evidence that new practice has been embedded
- Measuring and providing evidence of the impact of the changes

Appendix 1

References:

- The Children and Social Work Act 2017 (s.17) https://www.local.gov.uk/sites/default/files/documents/9.36_Get_in_on_the_Act_-_Children_02%20web.pdf

- Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

- The Child safeguarding Practice Review Panel: Rapid review examples (2022): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1124030/Child_safeguarding_rapid_review_examples.pdf

- The Child safeguarding Practice Review Panel: Child Safeguarding Practice Review Panel guidance for safeguarding partners (2022) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1108887/Child_Safeguarding_Practice_Review_panel_guidance_for_safeguarding_partners.pdf

- The Child safeguarding Practice Review Panel: Multi-agency safeguarding and domestic abuse (2022) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1107448/14.149_DFE_Child_safeguarding_Domestic_PB2_v4a.pdf