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The role of serious case reviews in improving the child protection system

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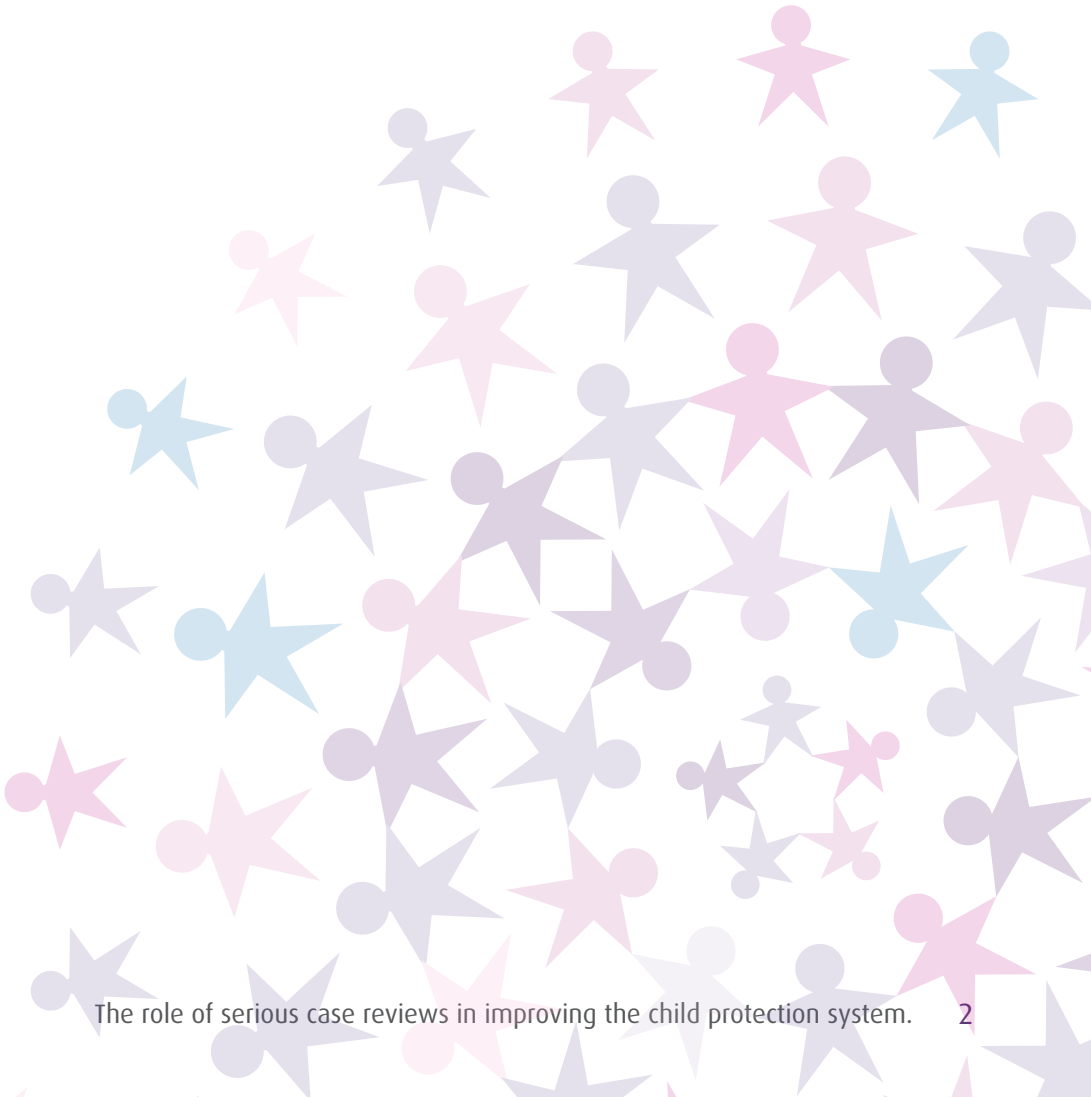

Introduction

"Abuse of children is not a disease entity but a pattern of behaviour and like all such patterns it has a multiplicity of paths by which it is reached." (Scott, 1973)

Serious Case Reviews (SCRs) are one of the mechanisms through which organisations can learn to protect children better. Reviews which focus on identifying learning can help organisations to change, and become environments in which both the systems and practice can be safely challenged and improved.

This paper provides the context for, and an overview of, a suite of materials which offers pointers to effective local management of the serious case review process, including an overview of the history of and rationale for SCRs and a brief exploration of some of the factors which make reviews of child protection practice and subsequent action to implement recommendations particularly challenging.

It was stimulated by discussions in government and local partnerships about the need to strengthen the process for review of cases giving rise to concern, in order to provide more effective explanations for the public and more effective learning for professionals. It followed criticism of a number of high profile SCRs and originated in a discussion at the Association of Directors of Children's Services Council of Reference in January 2014. At this meeting it was agreed to establish a Task and Finish Group chaired by the Virtual Staff College in order to consider how SCRs might serve better in contributing to sector learning following significant child protection cases. The drafting process was to include the Association of Independent LSCB Chairs (AILC), Social Care Institute for Excellence (SCIE), Research in Practice (RiP), NSPCC and The College of Social Work (TCSW).

The purpose of this work is to help sustain the focus of SCRs on learning and improvement (whilst acknowledging that this is not the only purpose) through offering a suite of support materials, which were developed by the group together with a set of questions/provocations that arose from the discussions of the group over a number of meetings.

With this in mind, the materials included in this publication, aim to assist LSCBs, Independent Chairs of LSCBs, Directors of Children's Services and other partners in setting up, handling and learning from serious case reviews, from the point of establishing arrangements for conducting reviews, through managing the process of a specific review and the outcomes, including any media interest.

The members of the Task and Finish Group hope that these papers and materials, although focused on England, will stimulate wide discussion and further development across the broad range of organisations involved closely in the safeguarding of children and young people.

Using these materials

This suite of documents provides pointers to practice supported by contextual analysis and academic reflection. It does not aim to provide a blueprint to be followed rigorously. Chairs, Directors and Boards should consider adapting the arrangements according to the specific needs of each case. The ideas, suggestions and views expressed throughout all of the associated documents are collectively owned by the Task and Finish Group and its members but are not necessarily representative of the individual organisations from which the membership was drawn.

We hope that there are practical suggestions for managing the process, which can be used to inform and guide the process of setting up a Review and that the leading LSCB members, LSCB Board Managers and senior managers will refer to the materials to stimulate reflection and to ensure that all factors are considered at each stage of the process of undertaking a serious case review.

Keeping children safe: The current context

Abuse of children is endemic in human society and takes multiple forms arising from many different 'causes', sometimes inter-connecting – injury, neglect, sexual and emotional abuse, bullying, sexual and labour exploitation, familial, organisational, institutional, cultural, criminal (Jones et al., 1987). The ill-treatment of children provokes understandably strong emotional reactions in professionals and the public, whether it be evidence of ill-treatment or of authoritarian intervention which disrupts family life, for example by removing children from parental care. Those involved in child protection work – professionals, courts, politicians – inevitably work in this highly charged arena. It is right that people do feel strongly about the treatment of children; the extremes of ill-treatment can be truly shocking. These emotional reactions must be anticipated when reporting new cases, however, and there should be an appropriate response, drawing on evidence and emotional intelligence.

A consequence of the emotive nature of the subject matter discussed in serious case reviews is that a very small number of SCRs become very high profile resulting in significant political and professional consequences. However, the risk that any SCR could potentially become high profile means that all reviews take place in an atmosphere that can make it difficult to be open and transparent, and to learn and create meaningful change.

Definitions and understandings of abuse vary widely and can be said to be culturally determined. For example, there are different views about the appropriate age for young people to work, get married, become soldiers and exercise individual responsibility. Parents' legal rights over children also vary. Attitudes towards and legislation about these matters are in a state of flux in our own society. Recent public and media concern about the sexual abuse of young people by 'celebrities' (Gray and Watt, 2013) highlights shifts in culture and in attitudes to the abuse of power within trusted institutions and in personal relationships generally.

These debates are taking place in the context of profound social and attitudinal changes, such as questioning of political and professional authority, breakdown of long-held assumptions about confidentiality in personal relationships and family life, including widespread use of social media (e.g. BASW, 2012), and 'idealisation' of childhood. It is therefore inevitable that child protection will remain an emotive area in the public domain within our own society and a public concern.

Serious case reviews – history and challenges

The use of formal inquiries to examine, understand and respond to scandals and untoward incidents can be seen in Victorian times and earlier. The background paper on the history of serious case reviews, forming part of this suite of papers, illustrates the evolution of case reviews and some of the issues, which have arisen. The use of inquiries and reviews to examine child protection 'tragedies' can be traced back through Maria Colwell (Department of Health and Social Security, 1974) to Dennis O'Neill (Home Office, 1945) and earlier.

There are inherent challenges in trying to understand why a case unfolded as it did. Hindsight bias, and the attractiveness of seeing 'human error' as an explanation for tragedy, can prevent truly nuanced and professionally useful explanations from being achieved. Inadequate, or over-simplistic, explanations, especially when focussed primarily on seeking to allocate blame, in turn make for misguided improvement activities. Other sectors, including healthcare, have struggled with these challenges and are, in many ways, further advanced in finding solutions. The fact that most people have personal experience of family life, and feel instinctively that they know what good child care looks like, means that child protection is not a remote, technical professional field but rather an activity where most people have an opinion and feel competent to make a judgement. SCRs will therefore always attract public interest.

Recent developments

In recent years, the spotlight has turned again to SCRs, questioning why they appear to have led to little practice improvement.

The Munro Review of Child Protection included specific consideration of the role of SCRs. The Review's final report (Munro, 2011) affirms the importance of ensuring that SCRs establish not merely a description of what professionals did, but also an analysis of why they acted as they did. Professor Munro also suggested that SCRs may be able to learn from developments in accident investigation techniques in other sectors, particularly the 'patient safety' agenda in health and accident investigation in aviation.

Working Together to Safeguard Children (Her Majesty's Government, 2013) recently revised (Her Majesty's Government, 2015) reflected the Munro Review (ibid.) recommendations. The statutory guidance focuses on requiring that SCRs provide good explanations of why professionals acted as they did, but without detailed specification of the SCR process, as Part 8 of the previous guidance had done. Under the new guidance, LSCBs are able to use any credible SCR methodology. Working Together 2013 also announced the establishment of an independent national panel 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 sector is still grappling with these changes. Many LSCBs are taking the opportunity to use different SCR methods but, to our knowledge, no systematic work has been done to compare experiences and share learning about which methodologies are helpful. There are also indications that further work and improvement is still needed: the first annual report of the national panel described the quality of SCRs as 'disturbingly variable', and containing detail 'not relevant to learning' (National Panel of Independent Experts on Serious Case Reviews, 2014).

Serious case reviews – a clear purpose?

Serious case reviews are one of the mechanisms, which exist to manage learning for professionals. They are also increasingly seen as assisting the management of public interest and political processes. Experience from the health sector suggests that these functions can have contradictory influences on review processes (Nicolini et al., 2011). An organisational learning agenda is likely to prioritise rapidity, quick local dissemination, and raising questions and problems that need addressing. Conversely, a public accountability agenda may prioritise a 'well-crafted' report, requiring longer preparation time, and demonstrating how identified problems have already been tackled. To our knowledge, the impact of these potentially conflicting purposes of SCRs has not been thoroughly explored. The different objectives certainly create tension in managing SCRs at all stages.

These factors – and the difficulties inherent in reviewing cases where children have suffered ill-treatment - make serious case reviews one of the most high profile and contested processes in current public service, vulnerable to the challenge that they make very little difference. Sustaining a focus on learning and avoiding a drift towards uncreative, safety-first and compliance driven practice is essential to meeting this challenge.

Serious Case Reviews – understanding practice

There is a real risk that retrospective case reviews will provide narratives which imply inevitability in the chain of events which result in serious harm or abuse and which therefore could (and should) have been predicted and prevented. That certainty in reality does not exist. Safeguarding decisions are almost always judgements based on incomplete evidence, frequently weighing competing risks and managing conflicts between the rights of different individuals. Evaluations of risk are judgements based on known risk factors, but these are rarely clear cut. By definition, judgement is just that and not a mechanistic process with a right or wrong answer (Munro, 1996). SCRs need to develop an understanding of the 'local rationality' of events and practitioners at the time, and avoid applying 'hindsight bias' (Munro, 2011). Research and experience do not provide a fail-safe framework for judgements and this should not be implied.

This means that it is important that SCRs provide a more nuanced understanding of the contextual factors underlying human judgement and mis-judgement (e.g. Dale and Mills, 2013) – so that improvement effort can be aimed at improving underlying conditions to support professional judgement, rather than just trying to further prescribe and control the role of individual professionals and allocate blame.

Organisational learning and change in practice

It is helpful in this context to distinguish between learning and improvement. Working Together 2015 indicates that the focus of SCRs should be on providing explanations for why mistakes and poor practice occur. Understanding the underlying reasons is not an end in itself, but is vital to informing improvements to practice. Such learning can be thought of as diagnostic, a necessary precursor for change and improvements to practice, and needs to be shared across LSCBs at local, regional and national levels.

However, action is then required in order to lead to improvement. We know that there are a number of factors that can help learning from SCRs:

1. **Getting the right kind of explanations and information** – Changes and improvement to practice need to be based on a detailed understanding of the reasons underlying poor practice. SCRs should therefore have a focus not just on 'what' happened in a case, but why – including consideration of the organisational context and systemic factors.

2. **Making the SCR a key element in a change process** – Meaningful involvement of staff, managers and senior managers in the process means that the SCR initiates the process of change by cultivating ownership amongst frontline staff and managers.

3. **Recommendations which encourage a realistic and strategic approach to change** – In the past, SCRs have led to action plans with large numbers of SMART[1] recommendations, which can encourage an over-simplistic and mechanistic approach to change. Recommendations need to be forward looking, less concerned with planning and process and more focused on providing Boards with strategic challenge and reflection. .

4. **Leadership that demonstrates learning to improve** – Changing multi-agency practice is unlikely to be straightforward or linear. Change depends on the actions of people at all levels of an organisation, shaped by organisational cultures, as well as written documents and strategies. SCRs should be seen in a wider context of learning and improvement, and of improvement priorities within different agencies.

1 Specific, Measurable, Achievable, Realistic and Timed.

Challenges – provocations for wider debate

This paper proposes some approaches to managing serious case reviews but we recognise that this does not address the wider questions, such as the shape and culture of the safeguarding system, the impact of substantial funding reductions in a range of public services for children and families, the cultures of public service agencies and the place of inspection.

Not withstanding this, we conclude with some reflections on serious case reviews within the wider safeguarding context:

Cultures of risk – All analysis of risk to children and young people recognises that ill-treatment and abuse appears to be inherent in the human condition and found in different forms in all societies. No amount of reflection on why poor practice occurred will eliminate all risk to children, although there is robust evidence that we DO reduce risk and professional intervention DOES improve the lives of hundreds of children. However, as the debate following the Oxfordshire Serious Case Review (2015) and other cases shows, risk is a result of cultural as well as individual characteristics. The lack of willingness in our society to honestly confront a culture which condones, and in some quarters actively celebrates aggressive sexual behaviour by men and negative stereotyping of women suggests that sexual exploitation of young women will continue in some form, for example. The history of the last 40 years and longer shows that social and political attitudes remain ambivalent about intervention in family life and the respective rights of children and parents. This creates an uncertain environment for practitioners and SCR authors.

Attitudes to adults and young people in difficulties - There are strong influences within our English culture which leap quickly to criticise and blame people for their misfortune and seek to punish young people with difficult behaviours. This makes it difficult to provide effective help. These cultural issues are often played out in the political arena – seen for example in public and professionals attitudes towards young women who are sexually exploited; until very recently they were frequently seen as wilful or delinquent but are now recognised as victims deserving our sympathy (evidence from Rotherham and Rochdale). This negative culture needs to be challenged, where appropriate. It is outside the remit of this paper to attempt a strategic analysis of trends in attitudes towards those with family problems and young people in particular. We do urge others to take up the challenge of analyzing these trends, in particular the impact of ambivalent political and public attitudes towards young people on our ability to intervene effectively to guide and assist young people in difficulties.

Accountability for the SCR report - The SCR process involves commissioning an independent person to review the case, usually drawing on independent management reviews (IMRs) written by managers in the agencies who have had no prior involvement in the case. The independent report stands in its own right as the conclusions of the author. However the methodology to be used is determined or approved by the LSCB and the quality of the final report is seen as the responsibility of the LSCB. Independent Chairs are increasingly expected to quality assure the final report and have been publicly criticised for agreeing to the publication of reports which are later subject to criticism, implying that they have the duty to insist on changes to improve the final report, whilst not detracting from the independent judgement reached by the author. It is now clear that the quality of the final report is not the sole responsibility of the independent author. The relationship between the Independent Chair of the LSCB and the independent author requires further examination and critical review.

Timing of publication - The publication of the SCR report can take place anything between several months and several years after the event in question. Managing the publication has become a ritual in itself, frequently removed from realities of day-to-day service management. Long delays are usually the result of court processes (prosecutions, coroner's hearings, care proceedings or disciplinary hearings). In most cases, any shortcomings identified and the recommendations made should have been actioned or resolved a long time earlier. More thought is required about the number and format of recommendations, given this context; does it make sense to publish recommendations in respect of service improvements which relate to a period one or more years earlier?

Engaging in wider social policy debates - The key role of the local authority to recognise and address wider social issues is of crucial significance to the LSCB and should be welcomed and encouraged. In turn, the LSCB has a monitoring but also a strategic role. The LSCB should therefore support the active identification and disruption of sexual exploitation. It also needs to recognise the implications for wider issues of governance affecting the LSCB, including the reality that this is outside the scope of its core business.

Organisational context and individual accountability - Our experience is that SCRs in their current configuration, have not given sufficient attention to organisational context and culture, focusing too closely on the facts of the individual case without seeking to understand the practice in its wider systemic context. Given the extensive reconfiguring of service delivery and funding reductions, the wider system factors are likely to become even more significant for understanding individual service problems. We welcome the successful innovation joint bid by SCIE, NSPCC and TCSW, working with AILC, for a learning and improvement hub that would provide swift, timely analysis of key factors with a focus on systems and support as well as practice.

We recognise that the skills and time required for organisational evaluation are frequently different from and are likely to be more demanding than the more narrow focus on an individual case. The implications of this for the commissioning and delivery of SCRs and the forensic and strategic skills and competences required in reviewers, need further exploration.

Organisational and professional learning - We recognise the need for organisations to focus more on developing reflections on practice, including reflections on formal procedures, but also more creative reflection on evaluating and developing assessment and practice skills, using the process to reflect, learn and generalise for the wider organisation and nationally. We also recognise that SCRs can help with information not only about characteristics of abusive families but also about organisational context, practice settings and effective practice skills. Providing this wider contextual analysis is also a responsibility of the inspectorates. We welcome the Government's decision to commissioning a continuation of the former biennial SCR research studies, which should help us to address these challenges. There is clearly a need to ensure that findings from individual case reviews or groups of reviews, which have wider implications, are disseminated more quickly, leading to speedy improvements when appropriate.

Involving practitioners - Discussions with frontline practitioners suggest that most do not read SCRs, even though they usually include much to inform practice improvements. Little attention is given to making SCRs readable and useful for practitioners, and they rarely contribute directly to the process. Practitioners need to be more involved in the process and enabled to contribute 'practice wisdom' and advice on implementation of recommendations. SCR Panels could draw on a 'frontline reference group' that would act as critical readers, advising on length, format, accessibility and – critically – the barriers to recommendations being implemented. This group could also act as dissemination leads, identifying the best methods for engaging practitioners with the messages from the SCR. A fraction of the overall cost of a SCR could be used to backfill their time.

Publication and professional learning - SCR reports are now written for publication and so inevitably anticipate the context in which they will be received and debated. There is an undisputed need for accountability and transparency and to increase public trust in the safeguarding arrangements, to which SCRs can contribute. However public debate in the media frequently over-simplifies the issues, primarily seeking to apportion blame. This may be appropriate in some cases. However in general this makes it difficult to undertake self-critical reflection and organisational learning. The ritual of individual humiliation may paradoxically be creating a more dangerous context for children and young people. Politicians and professional leaders have a responsibility to develop a review framework which balances accountability and organisational learning.

Inspection - At the time of writing, Ofsted has completed several reviews of LSCBs under the new inspection framework. The two pilots of a new approach to multi-professional inspection of the multi-agency LSCB structures and safeguarding arrangements resulted in a decision not to proceed with that model of inspection. Pilots of a multi-inspectorate framework for themed inspections of safeguarding were about to be launched at the time of writing. It is widely recognised that this approach to multi-inspectorate working is as challenging as the multi-professional work which is being inspected; the inspectorates have struggled to develop a workable model of partnership working, illustrating the inherent complexity of work in this area. Early results have identified a significant proportion of LSCBs judged to 'require improvement' with only a few 'good' and a number 'inadequate'. This activity is taking place within a wider debate about the role of inspection in times of austerity and how inspectorates make judgements arising from the inevitable tension between severe resource reductions and the quality of provision. Inspection has a role to play as one element in sustaining and improving service quality. The learning needs to be integrated with the findings from SCRs and other review processes. The manner and approach of inspection has a significant impact on organisational and learning cultures and the current climate suggests the need for reflection.

New partnerships between citizens and public services - Finally, we are aware of the need to establish a different relationship between formal services in general and families/citizens, in the context of continued austerity policies, increasing poverty and growing inequality. Ideas about how this should be undertaken are emerging and being explored. New approaches are essential if we are to provide safeguarding arrangements in times of austerity which command respect and which can respond appropriately to newly recognised as well as better understood forms of child abuse.

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Executive summary

This document presents the outcome of discussions of a small working group regarding four key questions.

1. What do we mean by learning?

- It is now clearer that the 'lessons' to be learned from SCRs should focus on underlying factors explaining why errors or mistakes occurred.
- The power to change these underlying factors rests with managers as well as practitioners – they are therefore a key audience for SCR findings.
- We need to distinguish between learning as a process and an outcome, and ensure that sufficient attention is given to embedding and evidencing learning.

2. What do we know about how to change practice?

- There is a substantial evidence base on this issue, including literature on learning organisations[1], organisational development, change management and action research[2]. However, much of this is from sectors other than social care.
- There is a lot of 'tacit' wisdom regarding organisational change in social care – could this be made more explicit, and brought to bear more frequently on SCR implementation?
- In the Health sector there is perhaps a clearer overarching framework regarding continuous improvement, and the nature of change in large organisations. This forms the backdrop for learning activities such as Root Cause Analysis.

3. What helps and hinders learning from SCRs?

- The SCR process can best lead to improvement when:
  - They gather the kinds of information needed to inform improvement
  - The SCR initiates the process of change by cultivating ownership amongst frontline staff and managers.
- The production of multiple action plans with large numbers of SMART recommendations tends to proliferate tasks – which makes the learning task more mechanistic, overwhelming and less likely to be effective.
- SCRs should be seen in a wider context of learning and improvement, and of improvement priorities within different agencies.

4. An overview of new models of SCR

- LSCBs now have the freedom to decide which model to use to conduct case reviews. The challenge for LSCBs is to understand the differences between various models and therefore decide which models might work best for each case.
- It is too soon yet to provide any commentary about the different benefits of the different models, or whether any particular models are particularly suited to different situations or different parts of the review process.

1 E.g. Senge, R. (1990) The fifth discipline. London: Random Century.
2 Summarised in National Co-ordinating Centre for NHS Service Delivery and Organisation (undated) Organisational change: A review for managers, professionals and researchers.

Introduction

This document presents the outcomes of discussions of a small working group comprising:

- The College of Social Work (Annie Hudson, Chief Executive)
- NSPCC (John Brownlow, Head of Professional Engagement, and Helen Walters, Knowledge Manager)
- Social Care Institute for Excellence (Amanda Edwards, Deputy Chief Executive and Hannah Roscoe, Interim Head of Learning Together. Additional written input from Sarah Peel, Interim Head of Learning Together and Trish Kearney, Director of Innovation and Development)

The group arose from the meeting of the Task and Finish group on SCRs, held on 24 January. This group has run alongside two other pieces of work to look at best practice for Chairs, and a reflection on the history and purpose of SCRs.

It was agreed that this group would look at the following question:

- 'How can professional systems better learn from, and embed the learning from, SCRs? How does this work for practitioners, managers, and the wider system?'

The group agreed to consider, and gather material on, the following four sub-questions:

1. What do we mean by learning?
2. What do we know about how to change practice?
3. What helps and hinders learning from SCRs?
4. An overview of new models of SCR

The aim was to consider these questions based on the collective knowledge of the group and our organisations – rather than to conduct a systematic piece of research. The remainder of this paper presents the results of our discussions and information-gathering, for consideration by the wider Task and Finish Group.

1. What do we mean by learning?

Agencies involved in safeguarding children are often urged to 'learn the lessons' from Serious Case Reviews (SCRs). But what do we mean by 'lessons'? And by whom do they need to be learned?

Until recently, there has not been a clear definition in statutory guidance. In the absence of this, SCR practice has created its own norms (Fish, 2012[3]). An (unsystematic) search through executive summary reports available on LSCB websites indicates that the terms 'lessons' and 'learning' are variously used to mean:

- Descriptions of a mistake or error - Learning = 'Primary care professionals did not share their concerns with children's social care'.
- A description of the remedial action thought to be required – Learning = 'Information sharing between primary care and children's social care must be improved'
- Explanations of a mistake or error – Learning = 'Common practice in which primary care professionals are not invited to strategy meetings means that they have limited opportunities to share concerns with children's social care'.

3 3 Fish, S. (2012) Beyond blaming to explaining – the future for Serious Case Reviews? Social Work Matters. The College of Social Work magazine. May 2012.

- Underlying reasons for a mistake or error having occurred – Learning = Social workers have a poor understanding of the role of primary care professionals or Due to workload pressures primary care professionals failed to prioritise attending strategy meetings, leading them to be left off invitation lists.

New guidance; further clarity

The new Working Together (2013) guidance helps us to define more clearly that we should be focusing on the last of these possible definitions. The guidance states that SCRs should be conducted in a way which:

- 'seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.' (Working Together, 2013: 67)

Seeking to understand underlying reasons is not an end in itself, but is vital to informing improvements to practice. Our ability to change and improve practice is dependent on having an understanding of why particular mistakes or failures occurred.

Who needs to learn?

A focus on the reasons underlying poor practice has implications for who needs to learn. The child protection sector has often assumed that the main 'learners' should be frontline practitioners, emphasising dissemination to staff through events, briefings and so on.

However, many underlying reasons – relating to supervision, conflicting priorities, resources and so on – are not within the gift of these practitioners to change. A key audience for this type of learning should be the managers, senior managers and commissioners able to tackle this order of issue.

Distinguishing 'learning' and 'improvement'

The process of learning can be thought of as 'diagnostic' – it should give us a clear understanding of what the underlying reasons for poor practice. But action is then required in order to lead to improvement. Services need to be able to show that we are now doing things differently and thereby improve the effectiveness of our interventions with children, young people and their families. Too often we have focused on the process of learning at the expense of improvement outcomes including:

- How to embed/sustain what we learn - difference between short and longer – term impact
- How to measure effectiveness of changes that we make?
- How to prepare for (and measure) any unintended consequence from change?
- How to create a culture within our organisations that is most conducive to learning taking place?

2. What do we know about how to change practice?

There is a large body of literature about how to bring about practice and organisational change, including literature on learning organisations[4], organisational development, change management and action research[5].

The gap at present is that we don't know enough about what has worked well in the context of social work, but we do know about organisational learning in other environments – eg. the health sector. Can we think more outside our own box in order to make better use of thinkers who focus is a different work setting – and what are the obstacles to doing this?

2.1 Approaches in social care

There is significant tacit wisdom regarding organisational change in social care – the question is whether this could be made more explicit, and whether we always take account of this knowledge in relation to implementing change following SCRs.

'Culture eats strategy for breakfast'

Importance of culture and 'how we do things round here', compared to written policies and procedures, is well recognised by leaders in children's social care. But is this recognised in all efforts to bring about change and improvement – particularly those originating from SCRs?

Interprofessional training and events

Breakdowns in interprofessional communication are one of the biggest and most enduring themes in SCRs – we should be unpacking this. Interprofessional training/events provide an important opportunity to challenge and tackle assumptions about other professions. It is important to create opportunities for professionals to 'walk in each other's shoes and exploring barriers to communication – e.g. value base, time, language, priorities.

A focus on cases

Helpful to do training/CPD which is focused on individual cases, rather than in the abstract.

Links with continuous professional development

Continuing professional development has the potential to be a key 'lever' for making organisational change a reality. However, we don't currently have a consistent CPD culture in social work/care, with professionals taking ownership for this. A stronger culture of CPD – and emphasising responsibilities as professionals to learn – could play a key role in organisational development.

4 e.g. Senge, R. (1990) The fifth discipline. London: Random Century.
5 Summarised in National Co-ordinating Centre for NHS Service Delivery and Organisation (undated) Organisational change: A review for managers, professionals and researchers.

2.2 Approaches to change management in Health

Key features of approach/thinking within the NHS:

- A commitment to continuous improvement through clinical governance - *"A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."*[6]
- An understanding that change in a large organisation such as the NHS is unlikely to be straightforward and linear, and may have unexpected emergent components.[7]
- A commitment to learning from adverse incidents, as set out in An organisation with a memory (2000).
- A commitment to development of an open, learning culture.[8]

A review conducted by the National Co-ordinating Centre for NHS Service Delivery and Organisation[9] sets out a number of models of change management, predicated on this approach and understanding of change. The review looks at models under the headings:

- How can we understand complexity, interdependence and fragmentation
- Why do we need to change?
- Who and what can change?
- How can we make change happen?

Recommended models for 'making change happen' include:

- Organisational development – using various 'levers' for change to prompt desired behaviours in staff – e.g. strategy, structure, culture, management style, physical settings and tools.
- Organisational learning models – a process which seeks to help organisations develop and use knowledge to change and improve themselves on an ongoing basis.
- Action research – seeing organisational change as a cyclical process where theory guides practice and practice in turn forms theory.
- Project management – imposing a discipline on to a defined change process.

Root Cause Analysis

Following the establishment of the National Patient Safety Agency in 2002, more than 8,000 NHS staff were trained in RCA. RCA forms part of a commitment to continuous safety improvement, by identifying root cause factors which can lead to error, and allowing these to be rectified.

Evaluation of RCA

To our knowledge, there has been no large-scale evaluation of the impact of RCA on practice and patient safety. However, a study by Davide Nicolini and colleagues[10] at the University of Warwick observed in detail the conduct of RCA processes at two large NHS acute hospitals, including putting the findings of RCA in to practice. It was found that:

6 DH (2000) An organisation with a memory. London: HMSO.
7 National Co-ordinating Centre for NHS Service Delivery and Organisation (undated) ibid.
8 DH (2000) Ibid.
9 National Co-ordinating Centre for NHS Service Delivery and Organisation, (undated) ibid.
10 Nicolini, D., Waring, J., Mengis, J. (2011) Policy and practice in the use of root cause analysis to investigate clinical adverse events: mind the gap, Social Science and Medicine, 73(2).

- The 'root causes' of problems identified often necessitated radical solutions, which were not easy to address. Discussions of improvement were therefore steered towards what was possible rather than what was necessary.
- The RCA process appeared to assume that responding to the RCA report was simply a matter of 'implementation' and was not oriented towards the long-term and complex organisational change task that was often needed.
- The underpinning logic of RCA is to lead to improvement through organisational learning, and promoting workforce involvement in service transformation. In practice, RCA was more often used to restore legitimacy after an adverse incident and treated as 'mini-public inquiries', meaning that more emphasis was placed on a polished report with clear recommendations than producing timely recommendations.

3. What helps and hinders learning from SCRs?

Organisational pre-requisites

A culture of learning and improvement - Learning from the Health sector suggests that SCRs and other types of review may lead to best learning and improvement when couched within a general agenda of continuous improvement and safety, and within an organisational culture of openness and learning.

A realistic approach to risk – it is not possible to eradicate risk entirely from child protection work. A more helpful and constructive approach is to be aware of risk, and actively manage it, rather than attempt to create an 'illusion of certainty'.

Putting SCRs in context - SCRs currently tend to be undertaken and presented as discrete pieces of work. But in fact they need to recognise context, including improvement priorities in the area, for different agencies. Current failure to do so hinders local, including practitioner, ownership for what might need to change.

A – SCR Process

In an individual locality

Getting the right kinds of information - If the desired 'lessons' from SCRs are explanations of reasons underlying poor practice, SCR processes need to be designed in such a way to elicit this type of information. That is, SCR processes should have an explicit focus on understanding why poor practice was observed, in a way which is oriented towards service improvement.

Involvement and ownership - Learning more likely if it is owned – an argument for directly involving people at all levels in the process itself. Different people may have different views of the causes of a problem and of the outcome that is desirable. The more hidden the review process the greater the likelihood that staff will experience being 'done to' by it rather than involved in it – and the greater the resistance, even unconscious, to the recommendations that result from it.

Motivations for doing the review - Drivers for change/doing review in the first place will likely affect the attitude to taking any learning forward. If drivers are compliance related, the outcomes are more likely to be too (action planning; RAG rating; Ofsted on shoulder). If drivers are client focussed, outcomes are more likely to be framed around what can realistically be done to develop a better service (development planning; client/staff testing; client group on shoulder).

Across the sector

Sharing learning from SCRs – This will be facilitated if SCRs are conducted in a manner which a) contains an inbuilt test of the wider applicability of the practice observed and b) the analysis uses a consistent framework. There also needs to be engagement with professional training establishments across sectors and with professional bodies e.g. The College of Social Work, The College of Policing and the Royal Colleges.

B - How issues are framed in the SCR report

Questions for consideration:

How many managers and practitioners will ever read a full report? Content and key messages therefore need to be clear and easily digestible. How can reports link in with the 'bigger' local picture, to help to support practitioner and manager ownership.

Do we need different reports for different audiences? Or – are we still crafting reports in ways that include unnecessary detail and which cloud the essential issues?

How important is the story of a case in relation to what people then remember about it and for how long?

To what degree can the content of a report help take forward the messaging – ie. pithy summaries rather than chronological unpicking of who did what when?

C - How to translate in to action and follow up

There is currently an unhelpful tendency to over-simplify complex issues when defining action plans

SCR research[11] is telling us that the production of multiple action plans with large numbers of SMART recommendations tends to proliferate tasks – which makes the learning task more mechanistic, overwhelming and less likely to be effective.

Brandon et al. (2011) in their analysis of recommendations from SCRs note:

"Most recommendations concerned procedures and training. The route to grappling with practice complexities like engaging hard to reach families, was usually more training and the compliance with or creation of new or duplicate procedures. Fewer recommendations considered strengthening supervision and better staff support as ways of promoting professional judgement or supporting reflective practice."

They further suggest that:

"Local Safeguarding Children Boards need to take responsibility for curbing this self-perpetuating cycle of a proliferation of recommendations and tasks and allow themselves to consider other ways of learning from serious case reviews. Recommendations may not be the best way to learn from these cases."

Sinclair and Bullock (2002:43), cited in Brandon et al. (2011) – There's a tendency to translate a rather big issue (parents who are hostile and lie) into something that can be measured and ticked...(such as)... awareness training.

11 11 E.g. Brandon et al. (2011) A study of recommendations arising from serious case reviews 2009-2010. London: HMSO.

We need recommendations which focus clearly on the desired outcome of change, rather than specifying the process in detail.

Is taking forward learning from SCRs being hampered by a lack of knowledge/innovation within social care about models of organisational learning and development?

- Does social care have an approach equivalent to the focus on patient safety in the NHS? If not, should it?
- It may be helpful to think outside the usual box and be prepared to use methods more akin to advertising to get key messages across, including presenting reports in different ways.
- Could we even move beyond just sending out paper reports, to develop more innovative change models – e.g. 'Champions for change' and similar.

It is helpful to see SCRs within a 'bigger picture' of evidence informing continuous improvement.

As with RCA, findings of SCRs may present complex problems. Seeing these findings within the context of ongoing, cumulative programmes of improvement may help to ensure that we do not just focus on the (immediately) possible.

Our experience suggests that it is important to:

- Prioritise what is most important rather than trying to do everything at the same time.
- Triangulate information about practice 'on the ground' coming in from various sources: audit, SCRs, staff surveys and so on.
- Consider who might be best able to take them forward – it may not be 'the usual suspects'.
- Cultivate a culture within organisations that both enables and is respectful of learning. It is more likely then that there will be existing processes (eg. practitioner forums; reflective practice groups) that can be used to take learning forward and that it won't be a one-off event – and that people won't be fearful of saying when things are not working well.

4. Overview of new models of SCR

The following is taken from a briefing paper prepared by the NPSCC information service.

NSPCC information service

Learning models for conducting serious case reviews in England

Working Together to Safeguard Children (DfE, 2013) specifies that serious case reviews and other case reviews "may use any learning model which is consistent with the principles in this guidance, including the systems methodology recommended by Professor Munro" (see Appendix).

Learning models being used to conduct case reviews

LSCBs now have the freedom to decide which model to use to conduct case reviews. The challenge for LSCBs is to understand the differences between various models and therefore decide which models might work best for each case.

This paper looks specifically at a number of systems methodologies, although the DfE has clarified that LSCBs do not need to use any of the established models, or they can use a combination of models, for different parts of the case review process.

It is too soon yet to provide any commentary about the different benefits of the different models, or whether any particular models are particularly suited to different situations or different parts of the review process.

It would be helpful if LSCBs were to share their experiences of using different models.

What is systems methodology?

In the past, serious case reviews have focused on what happened, ie what actions individuals did or did not take, and the results of that action (or inaction). There has not been much investigation into understanding why professionals behaved the way they did.

A systems approach aims to investigate the context in which professionals work in and to understand why professionals do not always adhere to the systems which are in place to keep children safe from harm.

Only by understanding why people do not behave as they are supposed to, is it possible to look for ways to change the system to improve safeguarding.

How does a systemic approach work?

A case review using systems methodology must be undertaken with people who were actually involved in the case. For this reason, it needs to focus on more recent agency involvement with the child and family (rather than examining the entire period of the child's life).

What systemic models are available?

SCIE Learning Together

The Learning Together (Fish et al. 2008) methodology is based on three core principles: avoiding hindsight bias; appraising and explaining practice; and moving from case-specific to more widely applicable systems learning. Case reviews are led by accredited reviewers, working collaboratively with a 'review team' of senior managers, and a 'case group' of the frontline staff who were involved in the case. Case group members take part in individual conversations, and also meet with the review team to provide input and feedback on the analysis of the case. The model can be used for non-statutory case reviews and SCRs.

SCIE Guide 24: Learning together to safeguard children: developing a multi-agency systems approach for case reviews - http://www.scie.org.uk/publications/guides/guide24/files/guide24.pdf

SILP (Significant Incident Learning Process)

SILPs have clear terms of reference and are led by an SILP-accredited reviewer. Case records are shared with practitioners and first-line managers in advance of a 'Learning Event'. A subsequent 'Recall Session' reviews what was captured from the original Learning Event and allows practitioners to feed into the final drafting of the overview report. SILP can be used as a stand-alone model for case reviews that do not meet the criteria for an SCR. The SILP principles can also be embedded into SCRs, creating a SILP hybrid model.

Appreciative Inquiry (AI)

Appreciative Inquiry focuses on what an organisation does well. The aim is then to build upon what works well rather than trying to eliminate what it does badly. It is used in a wide variety of contexts, and can be particularly relevant for organisations looking to provide higher standards of care. A strengths-based approach can help motivate members of an organisation to look for innovative and creative solutions to improve safeguarding. AI is a collaborative inquiry process which often relies on interviews and/or focus groups. It can include children and families, as well as all levels of an organisation. AI uses a cycle of 5 processes: definition; discovery; dream; design; and delivery/destiny. The outcome of AI is that the plans for change come from participants rather than from the reviewers.

Root Cause Analysis (RCA)

Root Cause Analysis involves looking ever-deeper for causes or contributors to significant incidents. Serious case reviews often identify symptoms of a problem, rather than getting to the bottom of why this problem exists. RCA aims to identify measures to tackle the root causes, rather than just providing superficial, short-term solutions. RCA is conducted by an investigation team. NHS website – Root Cause Analysis (RCA) investigation

http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

Failure Modes Effect Analysis (FMEA) FMEA is a systematic evaluation of complex processes to improve their safety. The process looks forward to anticipate what might go wrong and to find solutions to stop these failures occurring. FMEA involves mapping (in fine detail) all the processes in the system and then identifying all the potential errors that could occur at any point. These possible effects of these failures then need to be evaluated in terms of likelihood and severity before coming up with corrective actions for the highest risks.

Child Practice Reviews (CPRs)

In Wales, Child Practice Reviews have replaced serious case reviews. There is a 6-month timeframe for the completion of child practice reviews.

The CPR process is a collective endeavour to reflect and learn from what has happened in order to improve practice in the future, with a focus on accountability and not on culpability.

Child practice reviews are either 'concise' or 'extended', depending on whether the child was on the child protection register or looked after at any point in the six months preceding the incident that triggered the review.

Each child practice review is managed by a Review Panel and a reviewer is appointed to work with the Panel (two reviewers are appointed for an extended review). The review engages directly with children and family members (as they wish and as appropriate) and practitioners and their managers who have been working with the child and family. The review focuses on the practice during the previous 12 months.

A planned and facilitated practitioner-focused Learning Event is uses a systems approach to examine current case practice.

A draft report that is succinct and focused on improving practice and an outline action plan are produced and presented to the LSCB. The LSCB consider, challenge and contribute to the conclusions of the review and identify the strategic implications for improving practice and systems to be included in the action plan.

NSPCC factsheet: Multi-agency child practice reviews in Cymru/Wales

http://www.nspcc.org.uk/Inform/resourcesforprofessionals/scrs/wales_wda99597.html

Appendix

Excerpt from **Working Together to Safeguard Children (DfE, 2013)**

9. The following principles should be applied by LSCBs and their partner organisations to all reviews:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice.
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process.
- final reports of SCRs must be published, including the LSCB's response to the review findings, in order to achieve transparency. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections; and
- improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

10. SCRs and other case reviews should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children.
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

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Introduction

This document is part of the suite of documents designed to support LSCB Chairs with Serious Case Reviews. It contains a set of suggestions for ensuring the process is as effective as possible, built up from the experiences of a range of LSCB Chairs, academic reviews of Serious Case Reviews, evidence from the first National Panel Annual Report, and discussion between LSCB Chairs and colleagues from a range of organisations about to ensure Serious Case Reviews achieve the best learning possible.

It is designed to give LSCB Chairs some ideas about how best to approach the task. However, it's a set of suggestions, not a set of 'rules'. Every LSCB Chair will need to determine the most appropriate approach for their specific context, but this document can be used to assist.

It offers advice, broken down according to the following stages of the process:

- Stage 1 – Identification, initial action and decision making
- Stage 2 – Proportionality, Scoping and Commissioning
- Stage 3a – Working through it, getting to the learning quickly
- Stage 3b – Managing the people factor
- Stage 3c – Involving families, communities and everyone affected
- Stage 4 – Managing parallel processes and complexity
- Stage 5 – Relationships with the National Panel
- Stage 6 – Applying the learning, improving the practice
- Stage 7 – Publication and Communications
- Stage 8 – Monitoring and evaluating impact

Stage 1: Identification, initial action and decision making

- Have a protocol in place for all statutory partners to report their serious child care incidents (SCCI) /serious untoward incidents (SUI) / near misses into the LSCB Business Unit.
- Ensure all child deaths which meet the criteria for notification are reported to the LSCB Chair within 48 hours, with the LSCB Chair given a copy of the Notification. Where necessary, also inform the Chief Executive and Lead Member as well as the DCS.
- Notify agencies of the Notification and request that all files are immediately secured.
- After initial consideration by the SCR Sub group (or equivalent) and decision about the response to be made, ensure all incidents (SCCI) are reported to the LSCB Chair. (nb Ofsted expect LSCBs to monitor, and have a record of all SCCIs).
- The LSCB Chair and DCS should also be notified when it is determined that an incident that may require either a management/learning lessons review.
- Have in place a protocol governing referral of cases by the LSCB Chair to the National Panel in line with Working Together and National Panel guidance.
- Initiate short file/case reviews from all partners using a standard template, within first 7 days of the incident, with a recommendation from each agency about whether the criteria for a SCR are met.
- Put the individual reports together as short summary with the overarching recommendation from LSCB Business Unit for SCR Sub group (or its equivalent) to consider, applying both the regulations and the principle of proportionality.

- The SCR Sub group needs to makes a formal recommendation to the LSCB Chair, with a clear rationale behind it in relation to Working Together criteria, and with any recommendations about appropriate methodology.
- The LSCB Chair should always peer review their consideration, (using the Association's peer review process) and record their decision and rationale. The decision is the LSCB Chair's and theirs alone.
- Keep DfE, Ofsted, and the National Panel properly notified at each stage in decision making.
- Communicate the decision quickly to those involved in the case, verbally where possible, and formally in writing to all relevant agencies (remember others may need adding as further information emerges).
- Have a range of media handling approaches available to adapt and use if the incident itself draws attention.
- Keep the coroner informed of what has been decided as necessary.
- Have clear written records to support any submission to the National Panel, in particular, when the decision is to not undertake a SCR.

Stage 2: Proportionality, Scoping and Commissioning the Review

- When scoping the SCR and completing Terms of Reference, be flexible, clear, and concise. Include specific timelines, agencies to be included, and key questions to be asked/lines of enquiry to be explored (remember the ToR may change as it is an iterative process). Depending on the methodology chosen a full ToR may not be required.).
- Ensure the DCS and the LSCB Chair are sighted on, and actively discuss and contribute to, the proposed scope and / ToR for review.
- Ensure ToR are properly and flexibly designed to address the specific case – avoid 'boiler plate' ToR (but ensure common components are covered).
- Think through, as the scope/ ToR are drafted, the likely outcome, scale and nature of the review, and work back from final Report to in terms of what is needed.
- Ensure scope/ ToR focus on 'why this happened?' rather than 'what happened?'.
- Focus on achieving a process which provides 'learning through doing'.
- Proportionality is a helpful concept, so the scope / ToR needs to cover the process chosen as well as the areas to be examined. The greater the concern about what happened, or the more unusual the events were, the more forensic and comprehensive the review needs to be.
- Always consider whether Individual Management Reviews (IMRs) are needed, as well as the type of chronology you need (neither are now required – so the deciding factor should be what they will add to the process). Key events chronologies may be more useful, as well as short agency reviews. This will depend on the methodology selected.
- Determine the likely timescale and number of meetings required. Explicitly agree when the SCR will be finalised in draft and when the recommendations will be acted on regardless of external processes such as courts and inquests – don't wait for it all to finish.
- Build into the scope/ToR that the learning will be applied as soon as possible regardless of parallel processes and introduce a learning summary process from the start.
- Make sure you have decided who the review is primarily for and why (the victim, the family, the public, the government, the partners or a combination of these) and scope it accordingly. Some SCR's will draw huge public attention from day one.

- Identify what sort of panel, co-ordination, or management group you want to set up to lead the process before you finalise the draft scope/ ToR. Decide whether you want an Independent Review Chair as well as Lead Reviewer (neither are now required).
- Explicitly include the in scope / ToR the process arrangements in terms of liaison with the Senior Investigating Officer (SIO) if police investigations are underway, the coroner, and family members - as well as connections with any staff disciplinary processes or other review processes.
- Explicitly set out the expectations in terms of producing a publishable review Report – the scope/ ToR need to be clear about this from the start.
- The SCR Panel Chair or equivalent and the SCR Lead Reviewer should be selected based on consideration of:
  - The SCR content.
  - The evidence of their ability and skill.
  - Their specific experience and background.
  - Their demonstrable ability to use the methodology the LSCB Chair determines to be most appropriate.
  - Their willingness to collaborate and adapt during the process.
- Ensure the contracts with the SCR Panel Chair and Lead Reviewer specify that the LSCB Chair will hold final authority for any outputs, and will take editorial control if necessary.
- Consider including a lay member (properly advised and supported) on the SCR Panel or group managing the process – they often ask the sensible and obvious questions.
- Don't finalise the scope/ ToR until the first meeting of the SCR Panel or its equivalent have considered and commented on them – but the final decision is the LSCB Chair's.
- Do not become a slave to methodology. Mix and match methodologies to suit the situation rather than following the current trend. Agree locally with confidence, but be ready to debate your decision with DfE.

Stage 3a: Working through the review/getting to the learning quickly

- Recognise that this stage will vary depending on the methodology chosen.
- Ensure the key steps are all covered:
  - Chronology, data and information gathering.
  - Case summary preparation (identify key practice episodes/stages).
  - Debate, discussion and interactive learning processes (identify contributory factors and explore the 'why' questions).
  - Arrangements to engage families.
  - Rigorous analysis (patterns and themes followed by findings).
  - Draft overview Report and opportunity for debate.
  - Finalise recommendations and actions.
- Ensure the LSCB Business Unit fully understands and is monitoring the process.
- The Lead Reviewer should take recommendations to the LSCB Chair, DCS and LSCB Executive within first 4 weeks, 8, weeks and 4 months (or similar) as to immediate learning. The LSCB

can then begin to discuss activities to apply early learning.

- Ensure staff support across the system is in place and working – pick up any helpful feedback on process.
- Keep family members and SIO informed of decisions taken.
- Try to ensure the learning points being identified are outcome focussed, based on building learning, and linked explicitly to the recommendations. The recommendations need to set out the desired outcome as well as the action required to achieve it.
- Ensure the review Report is properly drafted to maximise the transparency of the learning but minimise the risks to those involved of being inappropriately identified, and don't include huge amounts of text about what happened. That can be done in a short objective and comment-neutral way rather than descriptively. Don't include the chronology, the genogram (if you used one) or the action plans in the review report. Do not include any critique of the IMRs if used (although a strong critique of the IMR's may be necessary at the SCR panel/ review steering group). If there are unresolvable differences of opinion amongst SCR Panel/ review steering group members it is acceptable for the Lead Reviewer to reflect those sensitively and draw their own judgements. Consensus is not necessarily achievable. A strong debate is a learning process but achieves nothing if it is played out in public – differences of view are however important.

Stage 3b: Managing the people factor

- There does not have to be a SCR Panel but if there is, (or a SCR steering group or equivalent) it is essential that roles, responsibilities, lines of communication, accountabilities, agreement for information sharing within agencies and authority are clearly agreed before the process begins (and preferably set out in any contract specification).
- The SCR Panel Chair and the Lead Reviewer should discuss concerns, barriers, issues, changes to scope/ ToR, delays, poor engagement by agencies and other challenges directly with the LSCB Chair.
- Ensure regular communication between Lead Reviewer, SCR Panel Chair (if there is one), Business Unit lead, Independent Reviewer (if there is one) and the LSCB Chair as well as the DCS. Remember the Report is presented to the LSCB who may choose to then add to it, write a formal response, or deliver a report based on it.
- Remember the SCR Report is ultimately the responsibility of the LSCB Chair and the final output is their decision. Make sure authors know and understand this before they start the task.
- Seek update reports to LSCB Executive or equivalent and actively debate any issues arising during process.
- The LSCB Chair should explicitly agree any changes to timeline and key milestones and ensure the DCS and Chief Exec of the local authority are informed .
- Ensure the SCR Panel understand the boundary of their authority, and recognise their independent report will be challenged.
- The LSCB Chair needs to ensure the report is properly quality assured and edited to their satisfaction. Be prepared to debate the balance between editing and quality assurance and accepting an independent analysis and conclusions.

Stage 3c:
Involving families, communities and everyone affected

- Always remember the impact of a child death, a serious incident, or a major conviction reaches far and wide.
- Ensure the family are properly informed, supported and advised throughout the process.
- Where possible involve the family as soon as the review begins and seek their views early. Where this is not possible work closely with the SIO, or a family liaison officer, social worker, advocate or lawyer or other individual involved in the matter.
- Decide on who is going to see or interview family members, who is going to share the final Report with them prior to publication and how it will be shared.
- Ensure the Lead Reviewer and/or independent reviewer do see key family members.
- Where appropriate the LSCB Chair should also see family members.
- Ensure affected staff are properly supported at every stage. Involve them as much as possible (parallel processes permitting).
- Remember everyone involved is, in some way, affected by what has happened – tread gently and sensitively as far as humanly possible.

Stage 4:
Managing parallel processes and complexity

- Appoint a legal advisor to the process at the point a decision is being considered; the LSCB Chair should seek their advice at each stage.
- The LSCB Chair may request LSCB commissioned legal advice to quality assure the Report and highlight areas of vulnerability.
- Identify ASAP whether other review processes may be required (for example, Domestic Homicide Reviews, Mental Health Tribunals, MAPPA Reviews and Adult SCRs) and set up a meeting of key players to agree which review process will take precedence.
- Take account of and follow as necessary the ACPO/CPS May 2014 Guidance for the Police, LSCB's and the CPS on liaison and the exchange of information where there are simultaneous proceedings.
- Explicitly set out what will happen if information arises that requires single agency criminal or disciplinary action and agree liaison and information exchange arrangements.
- Ensure there is strict version control and securely destroy previous versions. Maintain clear draft watermark through text until it is published.
- Have in place a LSCB protocol governing disclosure which can be applied immediately if requests for disclosure are received (which covers FOI requests as well as coroner's requests and criminal proceedings requests).
- Keep sighted on parallel timelines for other parallel processes.
- Establish a clear principle that no partner agency will release their review contributions unless it has been explicitly agreed with the LSCB Chair and complies with legal advice given by both that agency's legal advisor and the advisor appointed to the LSCB Board / SCR process.
- Ensure a protocol is in place to manage public interest immunity issues when drafts are requested by coroner or court and never just release a draft overview report, or a draft / finalised IMR (if undertaken) to court, CPS or coroner.

- Do not release material (including Individual Agency Reports) to other forms of inquiry or investigation (including a criminal investigation) without taking legal advice and ensure each agency understands this in order to avoid differential practice.
- Insist that CPS give adequate notice of their intention to view files and require them to clearly state what material they may want to use in writing.
- Unless the review is already published, always follow public interest immunity processes before any information is put in the public domain (family, criminal or coronial proceedings) This needs to be discussed formally by the LSCB Executive drawing on legal advice, and the LSCB Chair must take into account the Executive's advice before making a decision.

Stage 5: Relationship with the National Panel

- Remember the decision to undertake a SCR is the LSCB Chair's and theirs alone. Use that to ensure a very carefully thought out decision is arrived at.
- Take the over cautious approach and ensure decisions are reported to the National Panel for all SCCI's that have been notified to the DfE (whether yes or no decisions).
- The views about SCRs expressed in the National Panel Annual Report are helpful benchmarks to take into account.
- Ensure the LSCB Chair's reports to the National Panel are clearly set out, succinct, well evidenced and can demonstrate the rationale and analysis informing the decision.
- Use the National Panel's existence as an aide to sharpen thinking, rather than viewing them as an enemy.
- If the view is that publication must not take place, put the case together with as much supporting evidence as possible and submit to the National Panel in writing after carefully weighing up all the arguments.
- Never send a report in to the National Panel that cannot be defended or argued for; be clear on the answers and the rationale behind the decision.
- Seek advice from the DfE officials who support the National Panel if unsure.

Stage 6: Applying the learning, improving the practice

- As soon as it's been cleared by the SCR or Review panel / group, the first final draft of the review Report should be brought to the LSCB for debate and questions.
- Prepare LSCB members so responses are open rather than defensive and prepare the Lead Reviewer to be questioned and challenged themselves.
- Allow plenty of time to discuss the content; don't let anyone focus on grammar, typos or style.
- Keep asking 'why' at first Board discussion.
- Agree next steps and request that everyone reviews the learning points to ensure the recommendations are sensible, system wide and reflect the learning points.
- Prior to presentation of final draft to Board the LSCB Chair needs to ensure, through conversation and detailed review of draft, that: the content is tight, that reasons for incident are succinctly and objectively set out, that the what questions are clear but not laboured and the why questions are rigorously explored, and that the learning points relate to the desired outcomes and the recommended actions.

- Don't be afraid to bring in another professional to review the draft, edit it, or act as a peer reviewer for the Lead Reviewer if that is needed.
- Prior to presentation to LSCB, involve the DCS and Chief Executive of the local authority and make sure an SCR 'gold' group is set up with senior officers across system to start the implementation and publication processes.
- Present to LSCB within the 6 months regardless of where other processes are up to – the Report can be agreed in final draft and action taken straight away regardless of when the trial, inquest or both are scheduled to take place.
- Allow plenty of time for the LSCB to receive, discuss, and agree the final draft and to confirm exactly what the learning, recommendations and desired outcomes are.
- It is worth getting LSCB members to also sign up to leading on the various recommendations at that point.
- The LSCB may well wish to summarise and be ready to report on their debate upon receipt of the Report, adding in any additional learning and actions agreed at that point.
- Proceed with amending the learning and development strategy and training programme accordingly, and ensure that dissemination of learning is put in place after the final draft has been agreed and accepted. Don't wait to get a perfect action plan or for other processes to finish.
- Think about how you want to present/discuss the Report in governance and assurance terms; ensure each statutory agency involved actively takes the Report to their governing body for discussion and action.

Stage 7: Publication and Communications (Steering through shark infested waters)

- Have protocols in place before they are needed.
- Agree the basic principles in advance – the LSCB Chair represents the system so for any publication/communication process the LSCB Chair should always visibly represent (unless there are compelling reasons not to).
- Set up a gold or silver group outside the SCR process to manage communications and publication, negotiate tricky or disputed issues and get a common sign up to the lines to take and management of process.
- Clarify key dates that will influence Report publication and monitor any changes to these.
- Scan the media; be ready to identify potential issues at point of publication.
- Plan at the 6 month stage the likely approach to publication.
- Be ready to manage any outcomes such as inquest or court hearings before publication day.
- At least 6 weeks prior to publication, discuss the approach, debate and agree key messages and confirm the publication plan.
- Decide whether to publish proactively or reactively.
- If publishing reactively, have a strategy ready for any attention from media.
- Rehearse all participants fully in the Report's key messages; provide media training if needed.
- Agree a single point of contact (for example, a council press officer) to coordinate all press/media interest and activity and ensure they are working closely with press colleagues in all

participating agencies before and on the day of publication.

- Ensure DfE are properly briefed and informed about publication with a written strategy (and a copy of the Report) at least 7 days before publication.
- Agree who else may be asked to provide proactive statements, prepare these in light of the shared key messages, and agree where a single agency set of key messages may be required (this is rare but sometimes necessary).
- Avoid messages that simply say 'we have learnt the lessons' – it is unhelpful.
- Ensure all affected (and potentially vulnerable) individuals, especially family members, children's schools, carers and individual staff, are briefed and supported within half a day before publication. Have someone with them or on standby as necessary to support and protect them.
- Ensure the DCS briefs relevant politicians (local and MPs).
- Decide how far to go in briefing national organisations depending on likely scale of media interest.
- Follow the additional guidance on offer on managing publication.

Stage 8: Monitoring and evaluating progress and impact

- Monitoring and reporting on both individual agency action plans and the action plan arising from the SCR Report itself is essential; as is testing the impact of the actions in terms of changing practice.
- Action plans are generally iterative, so focus more on the learning points and desired outcomes than on the exact delivery of each recommendation – adapt them to suit circumstances and achieve real learning.
- Consider whether a baseline is needed to demonstrate impact, be proportionate in evaluation efforts, but be challenging. If claims are being made that practice has improved, this has to be backed up by evidence.
- Involve practitioners and managers across the system in evaluating the impact of the actions on practice; rather than just reporting on whether actions have been implemented.
- Build sampling of the impact of the recommendations and their implementation into the next year's audit and performance management system.
- Have a communication strategy in place to ensure the wider workforce are aware of practice improvements as a result of SCR findings – people need to know they are making progress just as much as knowing if they are not.

Conclusions

Every Serious Case Review is different, uniquely shaped to the circumstances under review. Ultimately it is the LSCB Chair that is accountable for the proper conduct of the SCR process, agreeing a robust Review Report and the creation of a learning culture to improve the way in which we support and protect children. This set of suggestions, drawing on the experience of LSCB Chairs, may help to navigate through the process.

ADCS
Leading Children's Services

ADCS virtual staff college
Developing People : Building Capacity

Exemplar - LSCB Communications Protocol

research in practice

scie social care institute for excellence

THE COLLEGE OF SOCIALWORK
The voice of social work in England

Association of Independent LSCB Chairs

Anywhere Local Safeguarding Children Board
Media relations protocol

Introduction

The LSCB brings together representatives from organisations across the local area to work in partnership to protect children and young people in the area.

Organisations represented are:

- Council (lead responsibility for safeguarding issues in the city).
- Schools and educational establishments.
- Police.
- Hospital Trust.
- NHS Trust.
- NHS Clinical Commissioning Group.
- NHS England.
- Fire Service.
- Voluntary/other organisations including 'early years' and 'early help' services.

This communications protocol aims to provide clear, concise guidelines on all communications activity carried out by the Board to ensure a co-ordinated approach to all reactive and proactive communications. There are additional communications challenges in situations where there is publication of a report, which is jointly published with another LSCB or area and similarly when the LSCB is publishing a report alongside the report from a Domestic Homicide Review or similar parallel process. Communications plans need to take account of the implications of such situations and the wider range of partners involved.

Responsibility of lead organisation

The Council's communications team acts as the main initial point of contact for all media enquiries. The team will also:

- Deal with all media activity focused on the safeguarding board, liaising as appropriate with individual organisations' communications leads. Media enquiries about operational safeguarding enquiries relevant to specific organisations will continue to be dealt with by the individual organisation.
- Log all media enquiries, recording actions and responses and providing a quarterly update to the board on all media activity.
- Liaise with all partner organisations, organising and chairing meetings of communications leads from all organisations.
- Lead on the development and delivery of communications strategies and plans for specific issues, supported by communications leads in all partner organisations.
- Provide specific media training and support to Board members acting as spokespeople on safeguarding board issues.

Responsibilities of partner organisations

- Provide a communications representative who can attend meetings of communications leads when required.
- Co-ordinate response or media spokesperson from their organisation if needed (acting as a single point of contact).
- Liaise with Council communications team to ensure media queries are dealt with promptly and transparently.

All media statements, responses and media releases to get final approval/sign off by the Chair of the LSCB or, in their absence, the Deputy Chair.

Communications approach and principles

The board's overall principles for communicating safeguarding issues are to:

- be honest, open and transparent about board issues wherever possible, recognising the importance of people's interest in, and understanding of, safeguarding issues.
- value media relations and communications activity as an effective way of raising the profile of the work carried out by the board to keep Coventry children and young people safe.
- provide the media with responses they need within their deadlines (where possible) and providing spokespeople where necessary (particularly for radio and television interviews) – aiming for balanced media coverage of safeguarding issues by ensuring the board's voice is heard.
- ensure a partnership approach to all safeguarding issues – speaking with one voice, on behalf of Coventry children and young people, putting their needs at the heart of all communications activity.

Co-ordinating communications activity

A close working relationship between communications leads in agencies/organisations is vital for effective co-ordination of media relations, particularly when there needs to be a rapid response to an urgent media enquiry. The following list sets out work programme for the group.

- Action – confirm a communications subgroup of all relevant communications leads to meet quarterly (twice a year) to share knowledge and experiences that can contribute to good communications support for the Board. It is proposed that the responsibility of chairing this meeting should be shared between the Council's communications lead and NHS Coventry and Rugby Clinical Commissioning Group's lead for an initial six month period.
- Action – list of contact details for communications leads for all agencies/organisations to be shared (including email addresses, mobile and out of hours numbers) between communications leads, each agency/organisation responsible for updating contact details when necessary.
- Action – agree standard 'notes to editors' text (around 200 words) to be used on all written media responses and media releases, including details of the aims and objectives of the board, its role and function and link to safeguarding board website.

Media enquiries about operational safeguarding enquiries relevant to specific organisations should be dealt with by the individual organisation. These queries don't require a response from the board as a whole. But in these cases it's useful for all partners to get an update about the media enquiry.

- Action – communications leads for all agencies and organisations to update rest of communications via email/phone call with details of media enquiry and response issued to media as and when necessary.

Media enquiries requiring a Safeguarding Board response will be co-ordinated by the Council communications team.

- Action - a draft response to a Safeguarding Board media enquiry, drafted by the Council's communications team and agreed by the Chair of the Board (or Deputy), will be circulated via email to all agencies/organisations with a deadline for response. As these responses will already have been cleared by the Chair (or Deputy) it should be assumed that agencies/organisations will only want amends in exceptional circumstances, so a nil response will be assumed to be assent. In some cases the Chair (or Deputy) may request specific input/comments/amends from a particular organisation – in these cases the Council's communications team will contact the communications lead by phone. Major issues (such as preparing for the publication of a Serious Case Review) will require specific communications plans and strategies to be developed. These will be produced on behalf of the board by the Council's communication team, with contributions from all communications leads.