Children's MARS Policy and Procedures

Improving Child Protection and Safeguarding Practice

December 2023

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Overview

Child protection in England is a complex multi-agency system with many different organisations and individuals playing their part. Reflecting on how well that system is working is critical as we constantly seek to improve our collective public service response to children and their families.

Sometimes a child suffers a serious injury or death as a result of child abuse or neglect. Understanding not only what happened but also why things happened as they did can help to improve our response in the future. Understanding the impact that the actions of different organisations and agencies had on the child's life, and on the lives of his or her family, and whether or not different approaches or actions may have resulted in a different outcome, is essential to improve our collective knowledge. It is in this way that we can make good judgments about what might need to change at a local or national level.

Definition

Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected **and**
- the child has died or been seriously harmed

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health[1]. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.

Purpose of child safeguarding practice reviews

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policy-makers. Understanding whether there are systemic issues, and whether, and how, policy and practice need to change, is critical to the system being dynamic and self-improving.

Reviews should seek to prevent, or reduce, the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose, including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings. These processes may be carried out alongside reviews or at a later stage. Employers should consider whether any disciplinary action should be taken against practitioners whose conduct and/or practice falls

[1] Child perpetrators may also be the subject of a review, if the definition of 'serious child safeguarding case' is met.

below acceptable standards and should refer to their regulatory body as appropriate.

Responsibilities for reviews

The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel (the Panel) and at local level with the safeguarding partners.

The Panel is responsible for identifying and overseeing the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance. The Panel should also maintain oversight of the system of national and local reviews and how effectively it is operating.

Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

In North Lincolnshire, the safeguarding partners have published their Children's Multi-agency Resilience and Safeguarding (MARS) Local Arrangements that point to this policy and procedure for identifying serious child safeguarding cases, commissioning a reviewer, reviewing and overseeing reviews of serious child safeguarding cases.

The Panel and the safeguarding partners have a shared aim in identifying improvements to practice and protecting children from harm and should maintain an open dialogue on an ongoing basis. This will enable them to share concerns, highlight commonly recurring areas that may need further investigation (whether leading to a local or national review), and share learning, including from success, that could lead to improvements elsewhere.

Safeguarding partners should have regard to any guidance that the Panel publishes. The Panel issued non-statutory guidance in September 2022 that should be read alongside Working Together to Safeguard Children 2018.

This guidance from the Panel:

- sets out the Panel's expectations of how the statutory guidance in chapter 4 of Working Together 2018 should be interpreted and implemented by safeguarding partners
- provides details on the processes of notification, rapid review and local child safeguarding practice reviews, the principles underpinning decision making, and what makes for good reviews
- provides an overview of the Panel and their role in learning and improvement
- outlines key points of how the Panel works, including their approach to national reviews

For further information see the Child Safeguarding Practice Review Panel guidance for safeguarding partners.

Duty on local authorities to notify incidents to the Child Safeguarding Practice Review Panel

16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) states:

Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if –

(a) the child dies or is seriously harmed in the local authority's area, or
(b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

Within North Lincolnshire notification of a serious child safeguarding incident will be made to the safeguarding partners via the Children's MARS team in the first instance using form **Serious Child Safeguarding Incident – Notification to Safeguarding Partners** available on the Children's MARS website.

Prior to notification, it is expected that the case has been discussed with the local authority safeguarding partner representative.

As per the Child Death Review Statutory and Operational Guidance (England) October 2018, the Child Death Overview Panel has a responsibility to notify the Panel and local safeguarding partners when it suspects that a child may have been abused or neglected. Such notification to the safeguarding partners will be made through the above form. Any notification to the Panel, will be made by the local authority following these procedures.

The safeguarding partner representatives will determine and agree whether the criteria are met to consider a CSPR and recommend to the safeguarding partners whether the local authority should notify the Panel.

As per the Panel's guidance for safeguarding partners, September 2022:

Discussion between safeguarding partners about cases and the decision to notify is crucial. Strong partnership working is predicated on collaboration and open dialogue. Where agreement cannot be reached through dialogue between the safeguarding partners alone, we encourage using the support of appointed independent scrutineers to help resolve differences.

Ultimately however, the final decision on whether or not to submit a notification to the Panel following an incident is the responsibility of the local authority.

If it is agreed by the safeguarding partners that the criteria are met, the local authority will notify the Panel within **5 working days** of becoming aware that the incident has occurred.

The local authority must **also** notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected.

The duty to notify events to the Panel rests with the local authority. Others who have functions relating to children[2] should inform the safeguarding partners of any incident which they think should be considered for a child safeguarding practice review. The link to the Child Safeguarding Online Notification form for local authorities to notify incidents to the Panel is available from [Report a serious child safeguarding incident page on Gov.uk.]

Decisions on local and national reviews

Safeguarding partners must make arrangements to:

- identify serious child safeguarding cases which raise issues of importance in relation to the area **and**
- commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken

When a serious incident becomes known to the safeguarding partners[3], they must consider whether the case meets the criteria for a local review.

Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice. Issues might appear to be the same in some child safeguarding cases but reasons for actions and behaviours may be different and so there may be different learning to be gained from similar cases. Decisions on whether to undertake reviews should be made transparently and the rationale communicated appropriately, including to families.

In such cases in North Lincolnshire the process in **Appendix 1: Flowchart 1** is followed.

The safeguarding partners have delegated the responsibility to the following representatives for them to consider the criteria and guidance and determine whether to carry out a local child safeguarding practice review:

- Designated Nurse and Head of Safeguarding (North Lincolnshire Health and Care Partnership)
- Assistant Director Children's Help and Protection (North Lincolnshire Council)
- Detective Superintendent (Humberside Police)

The safeguarding partners' representatives will consider the below criteria and circumstances and make a recommendation to the safeguarding partners about whether a local or national practice review should be completed or neither. In such cases, a Child Safeguarding Practice Review Group will be convened with the safeguarding partners' representatives as the core members.

See the section below on 'Guidance for the national Child Safeguarding Practice Review

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[2] This means any person or organisation with statutory or official duties or responsibilities relating to children.
[3] Safeguarding partners should also take account of information from other sources if applicable.

Panel' for the criteria for a national review.

The criteria which the local safeguarding partners must take into account include whether the case[4]:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children
- is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate

Safeguarding partners should also have regard to the following circumstances:

- where the safeguarding partners have cause for concern about the actions of a single agency
- where there has been no agency involvement and this gives the safeguarding partners cause for concern
- where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around
- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings[5]

The rapid review

The safeguarding partners should promptly undertake a rapid review of the case, in line with any guidance published by the Panel.

On 4 July 2018, the Chair of the National Panel notified safeguarding partners that a rapid review should be promptly undertaken in all serious child safeguarding cases and completed within 15 working days of the safeguarding partners becoming aware of the incident. This timescale was subsequently reaffirmed by the Panel in their practice guidance issued in April 2019.

In such cases in North Lincolnshire the process in **Appendix 1: Flowchart 2** is followed.

The aim of this rapid review is to enable safeguarding partners to:

- gather the facts about the case, as far as they can be readily established at the time
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately
- consider the potential for identifying improvements to safeguard and promote the welfare of children

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[4] The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018.

[5] Includes children's homes (including secure children's homes) and other settings with residential provision for children; custodial settings where a child is held, including police custody, young offender institutions and secure training centres; and all settings where detention of a child takes place, including under the Mental Health Act 1983 or the Mental Capacity Act 2005.

- decide what steps they should take next, including whether or not to undertake a child safeguarding practice review

During the rapid review process all agencies should consider the impact of the serious child safeguarding case on the welfare of the relevant staff and provide support that is in line with their organisation's policies and procedures.

As soon as the rapid review is complete, the safeguarding partners should send a copy to the Panel[6]. They should also share with the Panel their decision about whether a local child safeguarding practice review is appropriate or whether they think the case may raise issues which are complex or of national importance such that a national review may be appropriate. They may also do this if, during the course of a local child safeguarding practice review, new information comes to light which suggests that a national review may be appropriate. See the Child Safeguarding Practice Review Panel: Practice Guidance for additional information. As soon as the safeguarding partners have determined that a local review will be carried out, they should inform the Panel, Ofsted and DfE, including the name of any reviewer they have commissioned.

In such cases in North Lincolnshire the process in **Appendix 1: Flowchart 3** is followed.

The rapid review process will be facilitated by the Children's MARS team guided by the safeguarding partner's and their representatives. This will be undertaken via agencies providing a written report about the facts of the case and the potential for identifying improvements. There will be discussion between the representatives and any agency where clarity is required.

If information in relation to a rapid review or a child safeguarding practice review is believed to require a migration, border or citizenship related contribution from the Home Office, Chief Caseworking Unit should be notified at CCUsafeguarding@homeoffice.gov.uk.

The safeguarding partners' representatives will form a Child Safeguarding Practice Review Group and meet to evaluate agency reports and decide the next steps. This will include formulating their recommendation to the safeguarding partners about whether or not to undertake a child safeguarding practice review or whether they think the case may raise issues which are complex or of national importance such that a national review may be appropriate.

Guidance for the national Child Safeguarding Practice Review Panel

On receipt of the information from the rapid review, the Panel must decide whether it is appropriate to commission a national review of a case or cases. They must consider the criteria and guidance below.

[6] The Panel may share this with DfE if requested, to enable DfE to carry out its functions.

The criteria which the Panel must take into account include whether the case[7]:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
- raises or may raise issues requiring legislative change or changes to guidance issued under or further to any enactment
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children

The Panel should also have regard to the following circumstances:

- significant harm or death to a child educated otherwise than at school
- where a child is seriously harmed or dies while in the care of a local authority, or while on (or recently removed from) a child protection plan
- cases which involve a range of types of abuse[8]
- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings[9]

As well as considering notifications from local authorities and information from rapid reviews and local child safeguarding practice reviews, the Panel should take into account a range of other evidence, including inspection reports and other reports and research. The Panel may also take into account any other criteria they consider appropriate to identify whether a serious child safeguarding case raises issues which are complex or of national importance.

In many cases there will need to be dialogue between the safeguarding partners and the Panel to support the decision-making process. The safeguarding partners must share further information with the Panel as requested.

The Panel have given a commitment to respond promptly to the safeguarding partners with a decision on the majority of cases within 15 working days of a rapid review being received.

The Panel should inform the relevant safeguarding partners promptly following receipt of the rapid review, if they consider that:

- a national review is appropriate, setting out the rationale for their decision and next steps
- further information is required to support the Panel's decision-making (including whether the safeguarding partners have taken a decision as to whether to commission a local review)

The Panel should take decisions on whether to undertake national reviews and communicate their rationale appropriately, including to families. The Panel should notify the Secretary of State when a decision is made to carry out a national review.

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[7] The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018
[8] For example, trafficking for the purposes of child sexual exploitation.
[9] Includes children's homes (including secure children's homes) and other settings with residential provision for children; custodial settings where a child is held, including police custody, young offender institutions and secure training centres; and all settings where detention of a child takes place, including under the Mental Health Act 1983 or the Mental Capacity Act 2005.

If the Panel decides to undertake a national review they should discuss with the safeguarding partners the potential scope and methodology of the review and how they will engage with them and those involved in the case.

There will be instances where a local review has been carried out which could then form part of a thematic review that the Panel undertakes at a later date. There may also be instances when a local review has not been carried out but where the Panel considers that the case could be helpful to a national review at some stage in the future. In such circumstances, the Panel should engage with safeguarding partners to agree the conduct of the review.

Consideration of a Child Safeguarding Practice Review when the definition of a 'serious child safeguarding case' is not met

Some cases may not meet the definition of a 'serious child safeguarding case', but nevertheless raise issues of importance to the local area. That might, for example, include where there has been good practice, poor practice or where there have been 'near miss' events. Safeguarding partners may choose to undertake a local child safeguarding practice review in these or other circumstances.

If a professional from one of the safeguarding partner organisations, or from an organisation with statutory or official duties or responsibilities relating to children, believes that a Child Safeguarding Practice Review should be undertaken due to it meeting the definition above, they should discuss this with the safeguarding partners' representative or a senior manager within their organisation.

If the safeguarding partners' representative, or senior manager, believes that a case raises issues of importance to the local area they can request that the safeguarding partners consider a Child Safeguarding Practice Review. The request should be made via the Children's MARS team using the **Request to safeguarding partners for a case to be considered for a local Child Safeguarding Practice Review** form which is available on the Children's MARS website.

The safeguarding partners' representatives (the Child Safeguarding Practice Review Group core members) will discuss the case and determine the most appropriate and proportionate process to follow and make a recommendation to the safeguarding partners about whether they choose to undertake a Child Safeguarding Practice Review or not.

During the review process all agencies should consider the impact of the child's case on the welfare of the relevant staff and provide support that is in line with their organisation's policies and procedures.

In North Lincolnshire, where a case does meet the definition of a 'serious child safeguarding case' yet the safeguarding partners have agreed to undertake a Child Safeguarding Practice Review the process to be followed is in **Appendix 2: Flowchart 4**

Interface with other reviewing processes

Alongside any national or local reviews, there could be a criminal investigation, a coroner's investigation and/or professional body disciplinary procedures. The Panel and the safeguarding partners should have clear processes for how they will work with other investigations, including Domestic Homicide Reviews, Multi-agency Public Protection Arrangements Serious Case Reviews or Safeguarding Adults Reviews, and work collaboratively with those responsible for carrying out those reviews. This is to reduce burdens on and anxiety for the children and families concerned and to minimise duplication of effort and uncertainty.

In North Lincolnshire, the safeguarding partners and/or their representatives will liaise with the relevant lead for the other review process(es) to ensure that a parallel review process(es) are undertaken to reduce burdens on and anxiety for the children and families concerned and to minimise duplication of effort and uncertainty.

In such cases in North Lincolnshire the process in **Appendix 3** is followed.

Commissioning a reviewer or reviewers for a local child safeguarding practice review

The safeguarding partners are responsible for commissioning and supervising reviewers for local reviews[10].

In all cases they should consider whether the reviewer has the following:

- professional knowledge, understanding and practice relevant to local child safeguarding practice reviews, including the ability to engage both with practitioners and children and families
- knowledge and understanding of research relevant to children's safeguarding issues
- ability to recognise the complex circumstances in which practitioners work together to safeguard children
- ability to understand practice from the viewpoint of the individuals, organisations or agencies involved at the time rather than using hindsight
- ability to communicate findings effectively
- whether the reviewer has any real or perceived conflict of interest

For more information about the criteria for a reviewer, see **Appendix 4.**

Local child safeguarding practice reviews

The safeguarding partners should agree with the reviewer(s) the method by which the review should be conducted, taking into account this guidance and the principles of the systems

[10] Safeguarding partners may also consider appointing reviewers from the Child Safeguarding Practice Review Panel's pool of reviewers where available.

methodology recommended by the Munro review[11]. The methodology should provide a way of looking at and analysing frontline practice as well as organisational structures and learning. The methodology should be able to reach recommendations that will improve outcomes for children. All reviews should reflect the child's perspective and the family context.

The Children's MARS Board are committed to the use of a systems methodology where appropriate. Whilst the Children's MARS Board have developed a Local Systems Methodology Framework to undertake reviews of cases, it is recognised that the exact methodology utilised on a case will depend on the issues in the case and the reviewer.

For more information about the local systems methodology framework, see **Appendix 5.**

The review should be proportionate to the circumstances of the case, focus on potential learning, and establish and explain the reasons why the events occurred as they did.

As part of their duty to ensure that the review is of satisfactory quality, the safeguarding partners should seek to ensure that:

- practitioners are fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith

- families, including surviving children, are invited to contribute to reviews. This is important for ensuring that the child is at the centre of the process[12]. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively

The safeguarding partners must supervise the review to ensure that the reviewer is making satisfactory progress and that the review is of satisfactory quality. The safeguarding partners may request information from the reviewer during the review to enable them to assess progress and quality; any such requests must be made in writing. The President of the Family Division's guidance covering the role of the judiciary in SCRs[13] should also be noted in the context of child safeguarding practice reviews.

The President of the Family Division's guidance states:

It is apparent that there is widespread misunderstanding as to the extent to which judges (which for this purpose includes magistrates) can properly participate in Serious Case Reviews (SCRs). The purpose of this Guidance is to clarify the position and to explain what judges can and cannot do.

For important constitutional reasons, judicial participation in SCRs must be limited: therefore, judges do not respond to questions from SCRs, or requests from SCRs to complete IMRs, do

[11] The Munro Review of Child Protection: Final Report: A Child Centred System (May 2011).
[12] Morris, K., Brandon, M., and Tudor, P., (2013) 'Rights, Responsibilities and Pragmatic Practice: Family participation in Case Reviews'.
[13] President of the Family Division's Guidance covering the role of the judiciary in serious case reviews.

not attend evidence sessions or other meetings with SCRs and are under no obligation to provide information to SCRs.

Expectations for the final report

Safeguarding partners must ensure that the final report includes:

- a summary of any recommended improvements to be made by persons in the area to safeguard and promote the welfare of children
- an analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report

Any recommendations should be clear on what is required of relevant agencies and others collectively and individually, and by when, and focused on improving outcomes for children. For further information see the Child Safeguarding Practice Review Panel: Practice Guidance.

Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond, so safeguarding partners must publish the report, unless they consider it inappropriate to do so. In such a circumstance, they must publish any information about the improvements that should be made following the review that they consider it appropriate to publish. The name of the reviewer(s) should be included. Published reports or information must be publicly available for at least one year.

When compiling and preparing to publish the report, the safeguarding partners should consider carefully how best to manage the impact of the publication on children, family members, practitioners and others closely affected by the case. The safeguarding partners should ensure that reports are written in such a way so that what is published avoids harming the welfare of any children or vulnerable adults involved in the case.

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[14] before the date of publication. Where the safeguarding partners decide only to publish information relating to the improvements to be made following the review, they must also provide a copy of that information to the Panel and the Secretary of State within the same timescale. They should also provide the report, or information about improvements, to Ofsted within the same timescale.

Depending on the nature and complexity of the case, the report should be completed and published as soon as possible and no later than six months from the date of the decision to initiate a review. Where other proceedings may have an impact on or delay publication, for example an ongoing criminal investigation, inquest or future prosecution, the safeguarding partners should inform the Panel and the Secretary of State of the reasons for the delay. Safeguarding partners should also set out for the Panel and the Secretary of State the justification for any decision not to publish either the full report or information relating to improvements. Safeguarding partners should have regard to any comments that the Panel or the Secretary of State may make in respect of publication.

[14] 'Working day' means any day which is not a Saturday, Sunday or Bank Holiday.

Every effort should also be made, both before the review and while it is in progress, to (i) capture points from the case about improvements needed, and (ii) take corrective action and disseminate learning.

Actions in response to local and national reviews

The safeguarding partners should take account of the findings from their own local reviews and from all national reviews, with a view to considering how identified improvements should be implemented locally, including the way in which organisations and agencies work together to safeguard and promote the welfare of children. The safeguarding partners should highlight findings from reviews with relevant parties locally and should regularly audit progress on the implementation of recommended improvements[15]. Improvement should be sustained through regular monitoring and follow up of actions so that the findings from these reviews make a real impact on improving outcomes for children.

In North Lincolnshire, the Child Safeguarding Practice Review Group will take the leadership, in conjunction with the reviewer, on devising an action plan following the completion of a local child safeguarding practice review or a multi-agency local learning review. The group will regularly monitor and follow up on actions taken to ensure that the recommended improvements in agencies and how they work together to safeguard and promote the welfare of children are completed. This group will report regularly to the safeguarding partners also the Children's MARS Board and clearly demonstrate that the findings from a review has made an impact on improving outcomes for children. The safeguarding partners may decide to request that an independent scrutiny officer complete an audit/assurance event to ensure that the recommended improvements are embedded in multi-agency practice.

The Child Safeguarding Practice Review Group will continue to give oversight to the action plan until completion or with agreement from the safeguarding partners, the action plan will be monitored by the Safeguarding Practice Learning and Improvement Group (SPLIG). The action plan will be finally signed off by the safeguarding partners at the Children's MARS Board.

Guidance for the Child Safeguarding Practice Review Panel – reviewer

The Panel must set up a pool of potential reviewers who can undertake national reviews, a list of whom must be publicly available. If they consider that there are no potential reviewers in the pool with availability or suitable experience to undertake the review, they may select a person who is not in the pool. When selecting a reviewer, the Panel should consider whether they have any conflict of interest which could restrict their ability, or perceived ability, to identify improvements impartially.

For national child safeguarding practice reviews, the Panel should follow the same guidance on procedure and supervision as for local child safeguarding practice reviews.

[15] See Children's MARS Policy and Procedures Multi-agency Safeguarding Arrangements

The Panel – expectations for the final report

The Panel must ensure that the final report includes:

- a summary of any improvements being recommended to the safeguarding partners and/or others to safeguard and promote the welfare of children
- an analysis of any systemic or underlying reasons why actions were taken or not taken in respect of matters covered by the report

The Panel must publish the report, unless they consider it inappropriate to do so. In such a circumstance they must publish any information about the improvements that should be made following the review that they consider it appropriate to publish. The name of the reviewer(s) should be included.

The Panel should work with safeguarding partners to identify and manage the impact of the publication on children, family members, practitioners and others closely affected by the case.

The Panel must ensure that reports or information published are publicly available for at least three years. The Panel must send a copy of the full report to the Secretary of State no later than seven working days before the date of publication. Where the Panel decides only to publish information relating to the improvements to be made following the review, they must also provide a copy of that information to the Secretary of State within the same timescale. The Panel should also send a copy of the report or improvements to the relevant safeguarding partners, Ofsted, the Care Quality Commission and Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services.

Reports should be completed and published within six months of the date of the decision to initiate a review. Where other proceedings may have an impact on or delay publication, for example an ongoing criminal investigation, inquest or future prosecution, the Panel should advise the Secretary of State of the reasons for the delay. The Panel should also set out for the Secretary of State the explanation for any decision not to publish either the full report or information relating to improvements. During the review, the Panel should share any points that arise about improvements needed with the safeguarding partners in any local authority areas covered by the review and others as applicable.

The Panel should send copies of published reports of national and local child safeguarding practice reviews or published information relating to improvements that should be made following those reviews, to the What Works Centre for Children's Social Care and relevant inspectorates, bodies or individuals as they see fit. Where a local review results in findings which are of national importance, or in recommendations for national government, the Panel should consider the potential of those recommendations to improve systems to safeguard and promote the welfare of children and how best to disseminate and embed such learning.

Stage	Details
Serious incident notification	All serious child safeguarding incidents must be notified to the Panel. Notifications should be sent within five working days of the local authority becoming aware of the incident.

	Notifications are made through the online notification system which is accessible 24 hours a day.
The rapid review	Rapid reviews should be submitted to the Panel within 15 working days of the incident. This is a non-statutory requirement, and more details can be found in the Panel's practice guidance. Rapid reviews should be submitted to the Panel secretariat at: Mailbox.NationalReviewPanel@education.gov.uk
Local child safeguarding practice review	Full reports must be sent to the Panel and the Secretary of State for Education no later than seven working days before the date of publication. Final reports, information relating to improvements to be made following a review, and reasons for any delay, should be notified to Mailbox.NationalReviewPanel@education.gov.uk and Mailbox.CPOD@education.gov.uk In addition, final reports and information about improvements should also be sent to Ofsted SCR.SIN@ofsted.gov.uk.

Differences of opinion

The Children's MARS Policies and Procedures: Escalation and Resolution procedure outlines the below:

Should there be any differences of opinion about:

- *whether a case meets the criteria of a serious child safeguarding case*
- *whether a child safeguarding practice review or multi-agency local learning review should be undertaken or*
- *any part of the process*

the organisation(s) representative, who holds the difference of opinion, will liaise with the safeguarding partners/their representatives and the Children's MARS team in relation to this issue.

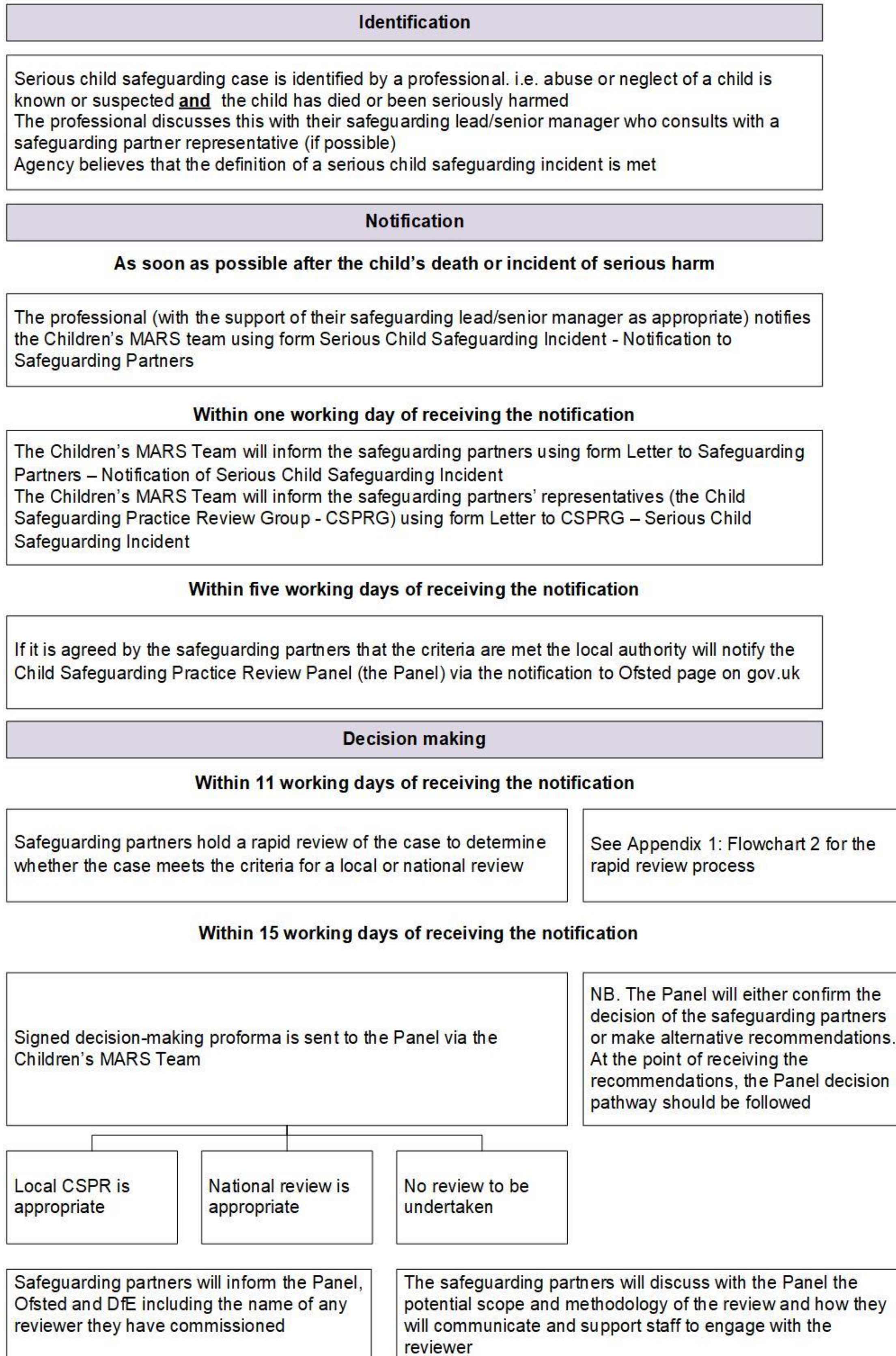
The safeguarding partners representatives are the Designated Nurse and Head of Safeguarding (North Lincolnshire Health and Care Partnership), Assistant Director Children's Help and Protection (North Lincolnshire Council) and Detective Superintendent (Humberside Police). The safeguarding partners representatives have been delegated the responsibility for making recommendations to the safeguarding partners.

Should the matter remain unresolved the safeguarding partner's representatives will refer the case to the safeguarding partners for them to reach a resolution.

If the matter remains unresolved, an Independent Scrutiny Officer will be requested to facilitate a mediation meeting with appropriate staff from the relevant organisations.

Appendix 1: Flowchart 1

Identification and notification of a serious child safeguarding incident and decision making regarding the undertaking of a child safeguarding practice review



Appendix 1: Flowchart 2

The Rapid Review Process

Working Day One

The Children's MARS Team will notify the safeguarding partners and the CSPRG of the notification via email within one working day using form Letter to Safeguarding Partners – Notification of Serious Child Safeguarding Incident

A rapid review meeting will be scheduled for the afternoon 11 working days after notification by the Children's MARS Team to enable the CSPRG to consider the information and make a recommendation to the safeguarding partners The Children's MARS Team will arrange with secretaries the time and date of the safeguarding partners telephone conference taking place on day 14

Working Day Two

The Children's MARS Team sends:

- Letter to CSPRG – Serious Child Safeguarding Incident to group members
- Rapid Review letter to safeguarding partners
- Agency Information for Rapid Review to the manager of all agencies who are working with the child/ family (or have worked with them in the previous 12 months) and in addition agencies who have been involved with the suspected perpetrator within the previous 12 months. Agencies will be given a 5 working day deadline to return the completed template. A letter accompanies this Rapid Review

The Children's MARS Team will follow up all emails by a telephone call to the agency to confirm receipt of the email and confirm expectation to complete and return the Agency Information for Rapid Review by the required date

Working Day Three to Seven

Agencies return the completed 'agency information for a rapid review' document to the Children's MARS Team.

NB: if by working day 7 the Children's MARS Team have not received a response from an agency, telephone contact will be made to ensure the report is available by the end of the day

Working Day Eight

The Children's MARS Team collates all agencies rapid reviews and nil returns on the Rapid Review Report for the CSPRG. This should be sent as early as possible on working day 8 to give the CSPRG time to read the reports

Working Day Nine to Ten

CSPRG read the Rapid Review report

Working Day Eleven

Rapid review meeting is held by the CSPRG. The Children's MARS Team will facilitate this meeting. Within the meeting the CSPRG will complete and agree the final version of the Recommendation to Safeguarding Partners and their Decision Record

Working Day Twelve

The Children's MARS Team send the completed decision record Recommendation to Safeguarding Partners and their Decision Record to the safeguarding partners for the partners to agree a response/decision. A letter accompanies the decision record

Working Day Thirteen

The safeguarding partners review the information on the Recommendation to Safeguarding Partners and their Decision Record

Working Day Fourteen

The safeguarding partners hold a telephone conference or meeting to discuss their agreed response to the CSPRG decision record. This is facilitated by the Children's MARS Team. The safeguarding partners summarise their agreed response/decision and sign the Recommendation to Safeguarding Partners and their Decision Record

Working Day Fifteen

The Children's MARS Team send the Decision of the Rapid Review of a Serious Child Safeguarding Incident letter along with the Recommendation to Safeguarding Partners and their Decision Record signed by the safeguarding partners and a copy of the Rapid Review to the Panel.

Appendix 1: Flowchart 3

Local child safeguarding practice review procedure

CSPRs should be completed with a 6 month time period

Decision made for a local CSPR

The CSPRG will agree the methodology, scope and terms of reference of the review which will include how independent views and challenges will be evidenced and whether an independent author will be appointed or how independent contributions will be made from across the local network. The methodology chosen will capture the views of service leaders, frontline practitioners and the family and focus on identifying areas that need further exploration. This will be endorsed by the safeguarding partners.

Details of the reviewer are provided to the Panel

If during the course of the local CSPR new information comes to light which suggest a national review may be appropriate this view should be shared with the panel

The CSPRG will review the progress and quality of the local CSPR at the relevant intervals requesting information in writing from the reviewer. The CSPRG will also capture ongoing learning about improvements needed and take corrective action. The safeguarding partners will be updated on the progress and agree to any learning being disseminated during the CSPR.

The final report will be published and will include:

Issues relating to race, ethnicity, religion, gender, sexuality, disability and poverty with an analysis of the impact of these on children and families that will form important contextual background to their circumstances and to the incident being reviewed

A summary of any recommended improvements to be made in the area to safeguard and promote the welfare of children

An analysis of any systemic or underlying reason why actions were taken or not taken in respect of matters covered by the report.

The final report will be endorsed by the safeguarding partners

The final signed report is sent, via the Children's MARS Team, to

the Panel

the Secretary of State

Ofsted

no later than seven working days before publication on the Children's MARS website

NB they must also be informed if the report will be published late or the full report is not to be published

The CSPRG will devise an action plan in response to the recommendations within the final report. The action plan will be regularly reviewed and the implementation of recommended improvements overseen by either the CSPRG or SPLIG as agreed by the safeguarding partners. The CSPRG will also communicate the findings and identified improvements to relevant parties

The safeguarding partners may decide to request that an independent scrutiny officer complete an audit/assurance event to ensure improvements are embedded into multi-agency practice

The Action Plan will be finally signed off by the safeguarding partners at the Children's MARS Board

Appendix 2: Flowchart 4

Local Child Safeguarding Practice Review – request for a case to be consideration for a Child Safeguarding Practice Review due to good practice, poor practice, where there has been a near miss event or in other circumstances

An agency identifies a case which will benefit from a Child Safeguarding Practice Review as it raises issues of importance for the local area (good practice/poor practice or where there has been a "near miss" event or in other circumstances). This should be discussed with the safeguarding partners' representative or a senior manager within their organisation who then discusses the case with a safeguarding partner representative.

If the safeguarding partners' representative, or senior manager, believes that a case raises issues of importance to the local area they can request that the safeguarding partners consider a Child Safeguarding Practice Review. The request should be made via the Children's MARS team using the Request to safeguarding partners for a case to be considered for a local Child Safeguarding Practice Review form.

The Children's MARS team inform the safeguarding partners that a request has been made.

The safeguarding partners' representatives (core members of the CSPRG) discuss the case and make a recommendation on whether to complete a Child Safeguarding Practice Review or not. The safeguarding partners will agree a response/decision.

The CSPRG will agree the methodology, scope and terms of reference of the review which will include how independent views and challenges will be evidenced and whether an independent author will be appointed or how independent contributions will be made from across the local network. The methodology chosen will capture the views of service leaders, frontline practitioners and the family and focus on identifying areas that need further exploration. This will be endorsed by the safeguarding partners.

The CSPRG will review the progress and quality of the local CSPR at the relevant intervals requesting information in writing from the reviewer. The CSPRG will also capture ongoing learning about improvements needed and take corrective action. The safeguarding partners will be updated on the progress and agree to any learning being disseminated during the CSPR.

The final report will be published and will include:

Issues relating to race, ethnicity, religion, gender, sexuality, disability and poverty with an analysis of the impact of these on children and families that will form important contextual background to their circumstances and to the incident being reviewed

A summary of any recommended improvements to be made in the area to safeguard and promote the welfare of children

An analysis of any systemic or underlying reason why actions were taken or not taken in respect of matters covered by the report.

The final report will be endorsed by the safeguarding partners

The final signed off report is published on the Children's MARS website upon agreement by the safeguarding partners and if appropriate

The CSPRG will devise an action plan in response to the recommendations within the final report. The action plan will be regularly reviewed and the implementation of recommended improvements overseen by either the CSPRG/SPLIG as agreed by the safeguarding partners. The CSPRG will also communicate the findings and identified improvements to relevant parties

The safeguarding partners may decide to request that an independent scrutiny officer complete an audit/ assurance event to ensure improvements are embedded into multi agency practice

The Action Plan will be finally signed off by the safeguarding partners at the Children's MARS Board

Appendix 3: Interface between safeguarding partners and those responsible for other notification and review processes

In North Lincolnshire, the safeguarding partners or a representative(s) will liaise with the relevant lead(s) for other investigations/procedures invoked at the time that a serious child safeguarding case is identified or at any time during the reviewing process as necessary. This may include the police investigating a criminal investigation, a coroner's investigation and/or professional body disciplinary procedures being undertaken.

In North Lincolnshire, the safeguarding partners or a representative(s) will liaise with the relevant lead for the other review process(es) to ensure that a parallel review process(es) are undertaken to reduce burdens on and anxiety for the children and families concerned and to minimise duplication of effort and uncertainty.

The principles are outlined below and it is acknowledged that a child safeguarding practice review may take place alongside more than one review process in exceptional circumstances.

Principles

These include:

- a system of notifying other agencies, partnerships or boards that a child safeguarding practice review is being considered and identifying whether any other review is taking place
- immediate discussion between the safeguarding partners or their representative(s) and the relevant lead, agency or partnership for the other review process(es) so that collaboration and initial planning is coordinated from the start of the reviewing processes to include a focus on the statutory requirements for those responsible to undertake a review
- joint or parallel rapid review of the case(s)
- joint or parallel initial evaluation of the case(s) against specific criteria for the reviewing processes
- discussion about any immediate action needed to ensure children's or adult's safety and how to share any early learning
- discussion about decision making to confirm the type of review(s) to be undertaken
- consideration of joint or parallel commissioning of a reviewer(s)
- agreement on the review(s) methodology and conduct including how children/family members or significant others and practitioners will be included
- agreement on the supervision of the reviewer(s) in terms of progress and quality
- expectations of the final report(s) to ensure that recommended improvements are clear and focused on improving outcomes for children and adults also that the underlying analysis is systemic in nature
- agreement and co-ordination of the publication of the report(s) and management of the impact of this on children and adults, family members, significant others, practitioners and others closely affected by the case
- agreement and co-ordination of devising an action plan(s) following the completion of the review(s) including disseminating learning and how these will be monitored to ensure that the recommended improvements are made with an impact on improving outcomes for

children and adults
- consideration of independent scrutiny to ensure that the recommended improvements are embedded in multi-agency practice

Yorkshire and Humber working principals

A set of working principals to be used when carrying out a safeguarding review (children or adults) or Domestic Homicide Review have been agreed across Yorkshire and the Humber.

These principals will be used when managing a Safeguarding Adults Review (SAR), Child Safeguarding Practice Review (CSPR) or a Domestic Homicide Review (DHR) alongside a police investigation by Humberside Police. These principles have been developed to enable both processes to run concurrently, and to support a timely response to both, and are to be used in conjunction with national guidance.

The Yorkshire and Humber working principals for safeguarding reviews document is available on the Children's MARS website.

Child safeguarding practice review and domestic homicide review

The safeguarding partners who make up the Children's Multi-agency Safeguarding and Resilience (MARS) Board are all members of the North Lincolnshire Community Safety Partnership (CSP) and the Chief Superintendent, who is a safeguarding partner, chairs the CSP.

Therefore, in relation to identifying, reviewing, commissioning a reviewer(s) and overseeing a child safeguarding practice review alongside a Domestic Homicide Review (DHR), the same strategic leaders are the decision-makers alongside the three other agencies that make up the CSP.

Overall responsibility for establishing a DHR and review panel rests with the North Lincolnshire CSP.

The chair of the CSP holds responsibility for establishing whether a homicide is to be the subject of a DHR by giving consideration to the definition within the statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 which states:

In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by –

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself,
- held with a view to identifying the lessons to be learnt from the death

NOTE: legislation states that words importing the masculine gender includes the feminine.

The Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) states:

'It should be noted that, when victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for child Serious Case Reviews, Safeguarding Adults Review and a Domestic Homicide Review. Consideration should be given to how these reviews can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case – for example, considering whether some or all aspects of the reviews can be commissioned jointly so as to reduce duplication of work for the organisations involved and provide an improved experience for families, subject to the final shape of the review meeting the requirements of both as set out in the statutory guidance.'

For further information, see the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) Home Office.

Child safeguarding practice review and a multi-agency public protection arrangements serious case review

The safeguarding partners are members or have representatives who attend the Humberside Multi-Agency Public Protection Arrangements (MAPPA) Strategic Management Board (SMB) that covers the Humberside Area. This includes Humberside Police as a Responsible Authority for MAPPA also the Duty to Co-operate agencies including North Lincolnshire Council and a representative from the North Lincolnshire Health and Care Partnership.

The chair of the MAPPA SMB has the responsibility to decide whether a case requires a MAPPA Serious Case Review (SCR).

The purpose of the MAPPA SCR is to examine whether the MAPPA arrangements were effectively applied and whether the agencies worked together to do all they reasonably could to manage effectively the risk of further offending in the community.

The aims of the MAPPA SCR will be to establish whether there are lessons to be learned, to identify them clearly, to decide how they will be acted upon, and, as a result, to inform the future development of MAPPA policies and procedures in order to protect the public better. It may also identify areas of good practice.

It is a MAPPA SMB responsibility to commission a MAPPA SCR when the mandatory criteria have been met.

The SMB must commission a MAPPA SCR if both of the following conditions apply:

- the MAPPA offender (in any category) was being managed at level 2 or 3 when the offence was committed or at any time in the 28 days before the offence was committed
- the offence is murder, attempted murder, manslaughter, rape, or attempted rape

It is an SMB responsibility to decide whether to commission a discretionary MAPPA SCR. There will be other Serious Further Offences that may trigger a MAPPA SCR. It is difficult to prescribe discretionary criteria as much will depend on the circumstances of the particular case

and whether there has been a significant breach of the MAPPA Guidance, but MAPPA SCRs might be commissioned when:

- a level 1 offender is charged with murder, manslaughter, rape or an attempt to commit murder or rape
- an offender being managed at any level is charged with a serious offence listed in PI 10/2011 or
- it would otherwise be in the public interest to undertake a review, e.g. following an offence which results in serious physical or psychological harm to a child or vulnerable adult but which is not an offence listed in PI 10/2011

However, as a review of the lead agency's management of the case will be conducted under these circumstances, careful consideration should be given to whether any value would be gained by conducting a MAPPA SCR for level 1 cases. This is especially relevant if cases have never been managed at level 2 or 3.

For further information, see MAPPA Guidance (2021) Ministry of Justice.

Child safeguarding practice review and a serious further offence review

The safeguarding partners or representatives will liaise with the Head of Probation Service (Yorkshire and Humber) to determine whether a Serious Further Offence (SFO) has been identified and whether a review is being undertaken.

The SFO procedures are intended to ensure rigorous scrutiny of those cases where individuals under the management of the Probation Service have been charged with a specified violent, sexual or terrorist offence (as per the list of qualifying offences is in Annex of Notification and Review Procedures for Further Serious Offences Policy Framework) in order that:

- the public may be reassured that Probation are committed to reviewing their practice in cases where supervised individuals managed by them are charged with certain serious offences
- areas for improvement and best practice are clearly identified, along with how and within what timescales action will be taken in respect of the former and what will be expected to improve as a result
- victims and their families can be provided with relevant information on how the individual was supervised and where there were shortcomings, how action to drive improvements has been, or will be, taken and
- Ministers, other senior officials and managers and the wider Ministry of Justice can be informed of high profile cases

The Policy Framework sets out the processes that must be followed when a supervised individual appears in court charged with a qualifying serious further offence. Further information is available in the Notification and Review Procedures for Further Serious Offences Policy Framework, Ministry of Justice and Her Majesty's Prison and Probation Service

Child safeguarding practice review and a safeguarding adults review

The safeguarding partners or representatives are members of the North Lincolnshire Safeguarding Adults Board (SAB) and also represented on the SABs Serious Adult Review (SAR) Group. Therefore, in relation to identifying, reviewing, commissioning a reviewer(s) and overseeing a child safeguarding practice review alongside a Safeguarding Adults Review, the same strategic leaders or their representatives have involvement, alongside other SAB members in the decision making process which enhances co-ordination of reviewing processes.

The SAB must arrange for a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. It is the responsibility of the three lead agencies for safeguarding to ask the SAR Group to consider whether a referral meets the criteria for a full safeguarding adults review. This recommendation must be taken back to the SAB chair for their final decision.

The SAB must also arrange a SAR if an adult in its area has not died, but the SAB knows of, or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect, where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life as a result of abuse or neglect. SAB's are free to arrange for a SAR in any other situations involving an adult in its area with care and support needs.

SARs can also be arranged to explore examples of good practice where this is likely to identify lessons that can be applied in future.

The SAB should determine what type of review will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. For more information see the North Lincolnshire Safeguarding Adults Board Policy and Procedures.

Child safeguarding practice review and notification of a serious incident to the Youth Justice Board

The safeguarding partners are members or have representatives who attend the North Lincolnshire Youth Justice Strategic Partnership Board. The responsibility for notifying the Youth Justice Board (YJB) of serious incidents that meet their criteria for reporting an incident lay with the Youth Justice Strategic Partnership. Should a child safeguarding practice review be undertaken for a child's case that meets the requirements for notification to the YJB, strategic leaders of the North Lincolnshire Youth Justice Strategic Partnership Board or their representatives would be involved in the reviewing processes.

The guidance on Serious incidents notification: standard operating procedures for youth justice services in England and Wales, Youth Justice Board, March 2022 outlines that from 1 April 2022 the YJB has introduced a mandatory system to report and record some

categories of serious incidents. This means that all youth justice services (YJS) are expected to notify the YJB when one of the following incidents have occurred.

The prescribed incidents must be notified to the YJB within one working day of a YJS becoming aware of an incident involving a child. If clarity is sought about the categorisation of incidents and the application of the procedures, then the YJB can be contacted via the serious incidents mailbox for guidance.

YJSs should notify the YJB of a serious incident if a child:

Is charged with committing one of the following notifiable incidents outlined below, (a full list of reportable incidents is included at Annex A of the Serious incidents notification: standard operating procedures for YJSs)

- attempted murder
- murder/manslaughter
- rape
- grievous bodily harm or wounding with or without intent – section 18/20
- a terrorism related offence

or

- dies while on the YJS caseload, or up to 20 calendar days following the end of YJS supervision

The notification should be submitted to the YJB within 24 hours of the charge being made or, in the case of the death of a child, the date the service became aware of that death.
In the event where there may be more than one YJS involved in the child's case, the expectation is that the completion of the notification will be the responsibility of the YJS that was delivering services to the child at the time of the incident.

All relevant YJSs that have information to contribute should do so, co-ordinated by the notifying YJS.

If the child is charged with committing a listed notifiable incident, the YJS that will be supervising going forward should report the incident.

The YJB has a statutory duty to monitor the youth justice system and share/promote good practice (Crime and Disorder Act 1998). Safeguarding principles as set out by government are embedded in this aspect of its work.

Intelligence related to serious incidents in the community supports the YJB's oversight of the whole system.

The guidance does not replace any local or national safeguarding requirements or policies. The YJB asks, in addition to requiring local YJSs to submit a serious incident notification, that all published reviews of any relevant notified serious incidents be submitted to the YJB via the serious incident's mailbox at the point of completion/publication.

The YJB does not require the submission of any internally produced learning reviews, only those that are published. For further information see [Serious incidents notification: standard operating procedures for YJSs]

Appendix 4: Criteria for an Independent Reviewer

The independent reviewer for a local child safeguarding practice review should provide evidence of an ability to:

- involve safeguarding partners and practitioners to contribute their perspectives without fear of being blamed for actions they took in good faith
- recognise the complex circumstances in which practitioners work together to safeguard children
- understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight
- distil findings and analysis from a number of studies and cases relevant to the review in order to inform the report's recommendations
- conclude with evidence-based recommendations which focus on professional learning and increasing expertise
- involve families, including surviving children, sensitively and transparently, so that they understand how they will be involved and have appropriate expectations. This is important for ensuring that the child is at the centre of the process
- work to an agreed schedule. In most cases this will be within a maximum of 6 months, with set dates for sharing drafts of a review with the North Lincolnshire safeguarding partners
- build relationships with relevant or interested parties quickly and instill their confidence
- deploy political intelligence, with an understanding of the critical levers for and obstacles to change
- handle information securely, being transparent about the way data is collected and analysed
- handle media attention sensitively and in consultation with the child safeguarding practice review group and the safeguarding partners in North Lincolnshire, having an awareness of how information affects the public domain

The independent reviewer must have knowledge, understanding and practice experience relevant to the ability to undertake and write a local CSPR. This may involve professional knowledge and practice specific to the case or cases under review.

For most cases a reviewer will be required to handle and quickly grasp the:

- complex circumstances in which professionals work together to safeguard children, including the impact of management, supervision, resources, skills and training
- relevant national and local legislative and policy frameworks within which services operate
- local and national safeguarding system, including an understanding of the critical levers for change, the priorities involved and how these interact across networks
- principles of the systems methodology recommended by the Munro review. The

methodology used by the reviewer should provide a way of looking at and analysing front line practice as well as organisational structures and learning. The methodology should be able to reach recommendations that will improve outcomes for children

Safeguarding partners and the Child Safeguarding Practice Review Group may require different or additional skills and experience from those listed above depending on the nature of the review.

Appendix 5: Local Systems Methodology Framework

Introduction

This Appendix applies to the completion of a:

- child safeguarding practice review undertaken when a case meets the definition of a 'serious child safeguarding case' (as per 16C (1) of the Children Act 2004 as amended by the Children and Social Work Act 2017)

- non-statutory child safeguarding practice review completed where the definition of a 'serious child safeguarding case' is not met, but the case raises issues of importance to the local area, as a result of identified:
  - good practice
  - poor practice
  - 'near miss' events

Values

This Appendix builds on reflections from The Munro Review of Child Protection: Final Report: A Child Centred System, the principles and ethos of the Social Care Institute for Excellence's (SCIE) Learning together to safeguard children: a 'systems' model for case reviews, and Sydney Dekker's "New View of Human Error"[16].

The Children's MARS Board is committed to utilising a 'systems approach' to undertaking reviews and will ensure any reviewers leading a review on their behalf adheres to the values, principles and framework outlined below.

During the decision-making process or in planning a review, safeguarding partner representatives and other agencies senior leaders should give consideration to the welfare of staff involved in the case and make arrangements for a multi-agency de-brief at the most appropriate time. This will be voluntary and may be informal or more structured.

Definition: Systems

When talking about '**systems**', people often think in terms of policies, procedures and protocols, hence the question: 'Are the appropriate systems in place?'

[16] As proposed by Sydney Dekker in "The Field Guide to Understanding Human Error", 2006, Ashgate Publishing Ltd, Farnham, Surrey.

However, in the systems review approach, the term is used in a far broader sense and includes all the possible variables that make up the workplace and influence the efforts of frontline workers in their engagement with families.

Importantly, as well as the more tangible factors such as procedures, tools and aids, working conditions, resources and skills, a systems approach also includes issues such as team and organisational cultures. These factors are treated as systems issues as well. (SCIE, 2012[17])

Aim of 'systems approaches'

The aim of a systems approach is not limited to understanding why specific cases developed in the way they did, for better or for worse. Instead, a case is made to act as a 'window' on the system (Vincent, 2004[18], p 242). It provides the opportunity to study the whole system, learning not just of flaws but also about what is working well.

A key value within these approaches is that individuals are not totally free to choose between good and problematic practice. The standard of their performance is influenced by the nature of:

- the tasks they perform
- the available tools designed to support them
- the environment in which they operate

These approaches, therefore, look at why particular routines of thought and action take root in multi-agency professional practice. It does this by taking account of the many factors that interact and influence individual worker's practice.

Ideas can then be generated about ways of re-designing the system at all levels to make it safer. The aim is to 'make it harder for people to do something wrong and easier for them to do it right' (Institute of Medicine[19], 1999, p 2).

Rationale for use of 'systems approaches'

We have two options in making sense of human error following accidents, incidents or mishaps. Dekker[20] proposes that the choice made determines the focus, questions, answers and ultimately the success of your efforts, as well as the potential for progress on safety in organisations and systems. He suggests that human error can be seen as:

- **the cause of a mishap** (Dekker describes this as the **Old View**)

This view focuses on the concept that unreliable people (Bad Apples) undermine basically safe systems. The purpose of investigations is to identify people's shortcomings and failings. During efforts to improve safety, we must make sure people do not contribute to trouble again

[17] Social Care Institute for Excellence (2012) Learning together to safeguard children: a 'systems' model for case reviews. At a glance 01.
[18] Patient safety, Vincent, C. (2006), quoted in SCIE (2012) Op cit
[19] Quoted in SCIE (2012) Op cit
[20] from Preface of Dekker, S (2006) The Field Guide to Understanding of Human Error pp x-xii

(so make more rules, more ‘automation’, more reprimands (blame).

- **the symptom of deeper trouble** (Dekker describes this as the **New View**)

This view seeks to explain how human error is a symptom of trouble (engineered, organised, social etc.) deeper inside the system, and that efforts to understand error begin with seeing how people try to create safety through their practice of reconciling multiple and often competing goals (safety, resource, performance targets, organisational/service priorities) in a complex dynamic setting. This New View recognises that people do not come to work to do a bad job. Safety in complex systems is not a result of getting rid of people or reducing their degrees of freedom. Safety in complex systems is ***created by people through practice –*** at all levels in organisations and systems. It is only people who have the flexibility to hold together the patchwork of tools, technologies and processes and do the work in environments where irreconcilable goals compete for their attention.

Dekker summarises these views in the tables below:

The Old View of human error on what goes wrong	The New View of human error on what goes wrong
Human error is a cause of trouble	Human error is a symptom of trouble deeper inside a system
To explain failure, you must seek failures (errors, violations, incompetence, mistakes)	To explain failure, do not try to find where people went wrong.
You must find people’s inaccurate assessments, wrong decisions, bad judgements	Instead, find how people’s assessments and actions made sense at the time, given the circumstances that surrounded them.

The Old View of human error on how to make it right	The New View of human error on how to make it right
Complex systems are basically safe	Complex systems are not basically safe
Unreliable, erratic humans undermine defences, rules and regulations	Complex systems are trade-offs between multiple irreconcilable goals (e.g. safety and efficiency)
To make systems safer, restrict the human contribution by tighter procedures, automation, supervision	People have to create safety through practice at all levels of an organisation

Hindsight bias

Hindsight bias leads us to grossly overestimate how obvious the correct action or decision would have looked at the time and how easy it would have been for the worker to do the right thing.

The central idea of systems approaches is that any worker’s performance is a result of both their own skill and knowledge and the organisational setting in which they are working.

Improving safety therefore means clarifying which aspects of the work context make errors more likely to happen, and which support workers to accomplish their tasks successfully. This clarification triggers ideas for re-designing the system at all levels to better support people to carry out their work to the highest standards.

A framework for understanding the influences on practice
Underlying patterns of systemic factors contributing to good or problematic practice

Good or problematic practice may, on the surface, look different in different cases, but the sets of underlying causes may be the same. Reviewers need to identify these 'patterns' of systemic factors that contribute towards good or poor quality work. They can be either constructive patterns of influence or create unsafe conditions in which poor practice is more likely.

SCIE have developed a six-part typology of patterns relevant to child welfare. Each highlights interactions involving specific elements of the system. In practice, however, the categories are not rigidly distinct but overlap. However, it provides a framework for organising the complex set of factors that influence work with children, families and carers:

1	Human–tool operation	e.g. the influence of assessment forms	Frameworks for the assessment of need and associated electronic and paper forms, such as specific assessment proforma and professional electronic recording databases/systems, are all tools. Instead of being seen as passive objects that help professionals do the same tasks as before but better or faster, they actually alter the nature of the task the human does. It is important, therefore, to find out how people and tools interact with each other and, over a period, change each other in complex and often unforeseen ways and examine whether these changes improve or hinder practice.
2	Human–management system operation	e.g. resource–demand mismatch	Management systems include: • resourcing issues • performance management and associated indicators • particular styles and content of supervision They are explicitly designed to influence practice. A systems approach can help

			highlight for senior management how they impact on direct work with families. This includes highlighting trade-offs that staff feel they are being encouraged to make between competing goals, such as completing a thorough assessment of a child and meeting the prescribed timescale and linked performance indicator.
3	Communication and collaboration in multi-agency working in response to incidents/crises	e.g. referral procedures and cultures of feedback	SCIE have identified that agencies tend to work relatively well together in crises where they are all using the same, well-established guidance which is in keeping with that in Working Together. Where any agency process varies from multi-agency agreed processes/ Working Together compliance, communication/ collaboration falters
4	Communication and collaboration in multi-agency working in assessment and longer-term work	e.g. understanding the nature of the task; assessment and planning as one-off event or on-going process?	In day-to-day work, the differences in the roles and responsibilities of different agencies in relation to different members of the family produce very varied patterns of working together. It is important, therefore, to distinguish the two.
5	Family–professional interactions	e.g. salience of the mother in social care involvement	Child welfare professionals do not just act on but interact with the people they are trying to help, and social and emotional interactions shape the nature of the work. A techno-rational approach tends to overlook the significance of the specific relationship a worker forms with parents and children and how this affects what information they receive, how they interpret it, and how they use it. Yet analysis of child abuse inquiries has revealed the powerful impact of the relationships, often in a destructive way.
6	Human judgement/reasoning	e.g. failure to review judgements and plans	Designing a safe system means taking into account people's psychological limitations and typical human errors of reasoning and then building in strategies for detecting and correcting these.

			One of the most common, problematic tendencies in human cognition, for example, is our failure to review judgements and plans - once we have formed a view on what is going on, we often fail to notice or to dismiss evidence that challenges that picture.

This framework for analysis is focused on the interactions between different parts of the system. Ideas can then be generated about ways of redesigning particular parts of the system in order to better keep children safe.

Heroic workers can achieve good practice in a poorly designed system, but efforts to improve practice will be more effective if the system is redesigned so that it is easier for average workers to do so. This approach enables cumulative learning from a series of case reviews. Because data is collected and analysed in a consistent way it is possible to make comparisons across cases.

Local rationality

A key assumption in a systems approach and a value held by Children's MARS Board is that human behaviour is fundamentally understandable: actions or decisions that later turned out to be mistaken or to lead to unwanted outcomes, seemed sensible to the individual at the time. It is, therefore, important to try and avoid hindsight in reviewing professional practice. Instead, it is necessary to reconstruct how people were making sense of an evolving situation. This is referred to as their 'local rationality': how the situation looked to someone at the time.

What the world looked like for each person involved will differ according to various factors including:

- what information was available to them
- what was capturing their attention
- what bodies of knowledge and experience they drew on to make sense of things
- the goals they were trying to achieve
- the conflicting priorities they were juggling.

The perspective from 'inside of the tunnel':
This is the point of view of people in the unfolding situation. To them the outcome was not known (or they would have done something else). They contributed to the direction of the sequence of events on the basis of what they saw on the inside of the unfolding situation. To understand human error you need to attain this perspective.

Reviews completed on behalf of the Children's MARS Board will consider:

- How the situation looked to those involved at the time
- How did the situation unfold around them: what cues did they get when?
- What goals were they likely pursuing at that time?

- The outcome of a systems review is rather than to make sense of the situation in hindsight we are trying to understand why things made sense to the people involved at the time and they then took the actions they did

Conversations

Understanding people's 'local rationality' requires talking with them, and having 'conversations'. This describes the process of establishing how the situation looked for someone better than 'interviews'.

Interviews, used to seek a formal view of an individual's activity, or establishing facts, is not well suited to the task of trying to see what the world looked like through someone else's eyes. Instead the concept of 'conversations' highlights that one of the main aims is to identify, respectfully, the approach taken by the person.

Who needs to learn and from whom?

Learning, like safeguarding, needs to be everyone's business. Learning through a systems approach must not be something only for managers to request that practitioners undertake:

- Front-line practitioners from different agencies and professions need opportunities to learn about and from each other
- Senior managers and policy makers need to be open to learning from those at the 'sharp end'

In a multi-agency context, it is increasingly difficult to predict with any certainty the impact of new policies and guidance, strategic and operational decisions on direct work with children, young people and families. Intelligent reforms can inadvertently create new problems. This is because reforms do not take effect in a vacuum. Instead each innovation interacts with others, as well as with existing aspects of practice. It is therefore difficult to predict with any certainty what the effects of any change to working practices will be. Translating policy aspirations into practice requires learning across boundaries of two different kinds:

- across agency and professional boundaries, and
- across hierarchical and management boundaries

However, any learning process needs to be acutely aware of the **opportunities**, and **challenges** which come from direct conversations that include front-line practitioners through to senior managers/ policy makers from across all involved services/agencies. In particular:

- front-line practitioners may be inhibited by openly discussing challenges in the system in which they are operating in the presence of their line-manager, or senior officer from their organisation
- senior officers may feel limited in sharing resource challenges which are beyond their control

Family involvement

Children, young people and their parents/carers need to be seen as active participants within the system and not outside it. As such, in order for a clear understanding of the 'system', it is

necessary to consider the appropriate involvement of family members in any review. Without family members key perspectives will be missed.

Where reviews are undertaken in cases which are not 'serious child safeguarding cases' then consent to complete the review **must be sought**.

Eileen Munro[21] suggested that
'in the majority of cases, families will consent to a review of how professionals endeavoured to help them in the past, if it is for the explicit purpose of trying to learn and improve the effectiveness of this help giving. Obtaining the consent of the child's family should, therefore, always be the first option to be considered by [those] *wishing to carry out case reviews* [which do not meet the criteria for a statutory review]*…If, for some reason, it is not possible or appropriate to seek consent from families, then* [those undertaking reviews] *will need to consider, on a case-by-case basis whether the review should and can lawfully be carried out without such consent. They will need to consider the purposes of the review, their powers for undertaking a case review and the Data Protection Act requirements to ensure that any sharing of information in such circumstances (i.e. without consent and for the purposes of a case review) is lawful and is appropriate.'*

Careful consideration needs to be given to how family are involved in the review process. Identifying key professionals who have a continuing relationship with the family, to work in collaboration with the reviewer to involve the family at an appropriate level should be explored.

Narrative of multi-agency perspectives

Fish, Munro and Barstow (SCIE[22]) in 2009 identified that:

- different professionals will inevitably have something of a differing view of a case
- getting to understand the 'why' questions about multi-agency working requires capturing these different multi-agency perspectives
- a usual 'chronology' is not helpful because it presents a unitary account and so tends to erase differences
- a more novel-like structure better captures a diversity of perspectives or multiple narratives
- it is 'a major fault to assume that we all share the same picture of reality'

The nature of different agency involvement with families and the nature of different roles within agencies mean that there will invariably be a diversity of perspectives, although the differences can range from slight to radical.

Within the SCIE document, Fish et al identify that it becomes important to move beyond the basic factual detail of a case, such as that in a chronology. **Instead what is required is to recognise and coordinate the different 'local rationalities' of individuals and agencies, to establish a set of multiple and differing perspectives.**

[21] The Munro Review of Child Protection: Final Report: A Child Centred System

[22] Learning together to safeguard children: developing a multi-agency systems approach for case reviews. Children's and Families' Services SCIE Guide 24, 2009

Key practice episodes

In order to achieve these perspectives it may be helpful to identify Key Practice Episodes:

- significant episodes that require further analysis
- may include particular actions/inactions or can extend over time
- may be good or problematic
- are likely to be a selection, not all episodes in a case, but may be judged to be significant to understanding the way that the case developed and was handled

Contributory factors

In analysing multi-agency activity it may be useful to clarify contributory factors which could include all the possible variables that make up the workplace and influence practice. They are not just policies, procedures and protocols, but include 'softer' factors such as team and organisational cultures.

SCIE developed a single framework of contributory factors relevant to child welfare work. These are divided into three different levels reflecting where in the child welfare system they originate: front-line, local or national.

- Front-line factors:
  - aspects of the family
  - personal (staff) aspects
  - aspects of the role
  - conditions of work
  - own team factors
  - inter-agency/inter-professional factors
- Local strategic level factors:
  - organisational culture and management
  - resource allocation
- National/government level factors:
  - political context and priorities

Accountability and responsibility within systems reviews

Whilst 'Systems Approaches' seek to view individual behaviour in the setting and the sense people made at the time, it is not an approach which allows for tolerance of absence of accountability. Within a systems review, those involved will consider whether the information made available and the subsequent decisions made sense to others. Where it is recognised any other practitioner would have done the same thing as the one whose assessments and actions are now controversial, the substitution test will be applied. If you substitute one practitioner for another and imagine the same thing would have happened, the focus for learning needs to be on the system NOT the individual. However, if this 'substitution test' cannot be applied and there are concerns regarding an individual's conduct, these should be dealt with through individual agencies professional conduct/ disciplinary procedures.

Leading a review

This section does not propose any specific methodology. However, reviews commissioned and undertaken on behalf of the Children's MARS Board should follow the principles outlined below:

The **methodology** will (unless clear rationale is identified):

1. include collaborative participation of:
   - Front-line practitioners
   - Operational managers
   - Senior managers and policy makers
   - Children, young people and their family/carers

To allow for full engagement by all involved in cases, consideration may need to be given for individual/group conversations utilising a matrix approach.

2. view 'accidents' as emerging from interactions between components and processes rather than failures within the system

3. seek to provide a window of opportunity to review a system and the experiences of the practitioners at all levels in that system

Values

The Children's MARS Board believes that systems are not basically safe – with people in them having to create safety.

Those involved in reviews will take all reasonable measures to:

- avoid hindsight bias
- reject the person centred approach to human error
- recognise errors are not the cause of trouble; they are consequences of symptoms
- attain individuals 'local rationality' – what sense practitioners and children, young people, families and carers made of the situation at point(s) in the process
- recognise that people are a source of safety
- identify human error as the starting point and not the conclusion of an investigation
- recognise sources of error are structural not personal

Selecting a reviewer

In selecting a reviewer, consideration will be given to the following features:

- the review will be led by one or more individuals who have had no direct involvement in the management of the case
- the involvement of at least one reviewer who has no professional connections to services in North Lincolnshire may help practitioners or the children, young people, families and carers to engage openly in the process
- undertaking a systems review requires a team to lead, or support, the review process. It cannot be the responsibility of a single individual

- the professional and/or the knowledge of local arrangements, in leading/supporting the review may be beneficial
- reviewers will need to be supported by key individuals from across involved agencies/services in completing the analysis

Identifying key lines of enquiry and setting terms of reference

The reviewer, the safeguarding partners, will set the terms of reference for any review and/or their representatives and senior officers involved in the review. Other professionals may also be used, as appropriate, dependent on the case.

The information shared at Child Safeguarding Practice Review Group or the Safeguarding Practice Learning and Improvement Group, depending on where the decision was taken to complete the review, will inform the key lines of enquiry and questions which the review should address.

The key lines of enquiry could arise from the identification of key practice episodes.

The terms of reference will be approved by the safeguarding partners.

Time period of review

The time period reviewed will be dependent on the key lines of enquiry or key questions. It is highly likely, but not definite that the review will explore a period of time leading up to the incident which precipitated the review.

In some circumstances, exploration of a theme or themes over a longer period of time will be identified in order to get a window on the system and to gain some understanding about what sense practitioners made of the context of work they were involved in i.e. the perspective from 'inside the tunnel'.

Identifying who should be involved

All front-line staff who were/are working with the child, young person, family and carers should be actively involved in the review. They provide a source of information and will contribute to the analysis.

Given their management roles and responsibilities related, for example, to supervision, budgets and performance indicators, it will be important to include significant first-line supervisors/managers.
Senior managers and policy makers need to be open to learning from those at the 'sharp end'.

Gathering information

In identifying the information which is required to be considered, it should allow for responding to the questions identified in the terms of reference. This approach should be taken, rather than taking a 'shopping bag approach' where all incidents and cues are collected and provided

to the reviewer in a way which it would not have been available to individuals operating within the system. The 'shopping bag approach' encourages hindsight bias and does not assist in trying to understand how people made sense of the situation at the time.

The gathering of information should focus on reconstructing the 'local rationality' for individuals/ services.

Analysis

Analysis will focus upon 'why' incidents occurred and where in the system the causal factors lie.

Analysis of the information available will take place whilst noting that:
- there is no absolute truth about a case and putting together the various accounts requires interpretation by the reviewer
- participants provide a vital check on basic accuracy of the facts
- participants also need to validate the prioritisation of issues by the reviewer

The analysis may include:
- identification and prioritising generic patterns of systemic factors
- identification of contributing factors

Reports

Reviewers will prepare a report based on the issues identified within the review that may include:
- a narrative of agency involvement in the case
- individual organisation and multi-agency reflections arising from the review
- key practice episodes that participants and the reviewer believe to be significant
- reflecting on contributory factors from across the various participants accounts
- identifying findings
- making recommendations

Making recommendations

In completion of systems reviews there needs to be an acknowledgement that not all findings can be transferred into specific, measureable, achievable, realistic and time-bound (SMART) recommendations. Understanding the complex influences on practice does not mean that there are any simple solutions. Learning, like safeguarding, needs to be everyone's business. This is a system wide approach and improving practice can require change from people at all levels of the system, not just on the part of front-line practitioners.

SCIE identify the possibility of three different kinds of recommendations that can be distinguished as issues:
- with clear cut solutions that can be addressed locally and by all agencies relevant to the review

- where solutions cannot be so precise because competing priorities and inevitable resource constraints mean there are no easy answers
- that require further research and development in order to find solutions, including those that would need to be addressed at a national level