SEFTON LOCAL SAFEGUARDING CHILDREN BOARD (LSCB)

REPORT TO SEFTON COUNCIL OVERVIEW & SCRUTINY COMMITTEE
26 JANUARY 2021

REPORT TITLE:	Sefton LSCB Report on Serious Case Review Activity
REPORT AUTHOR:	Paula St Aubyn, Sefton LSCB Independent Chair
BACKGROUND:	Sefton LSCB is providing this report as an overview of Serious Case Review activity.
RECOMMENDATIONS:	Sefton LSCB to provide an annual overview report to Sefton Council Overview & Scrutiny in relation to Serious Case Reviews in Sefton.

Sefton Local Safeguarding Children Board (LSCB)

Report on Serious Case Review (SCR) Activity

Introduction

Sefton LSCB has to date completed and published 5 SCR's. This report provides detail to the national and local processes followed in relation to this activity as well as the work undertaken to address the identified partnership learning. It is of note that none of the published SCRs concluded that any child death was preventable.

Purpose of these 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."

Working Together to Safeguard Children 2018

The LSCB reviews are undertaken to maximise any learning we can extract to the benefit of the whole partnership in improving its practice where gaps may be identified. It is not driven to apportion blame to any individuals or single agencies. Sefton LSCB has worked hard to create and achieve an inclusive, transparent and safe working environment for all agencies to contribute openly and honestly within this process.

Legal requirements

In England, child safeguarding practice reviews (previously known as serious case reviews) should be considered for serious child safeguarding cases where:

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

This may include cases where a child has caused serious harm to someone else.

Serious harm includes but is not limited to, serious and/or long-term impairment of a child's mental or physical health or intellectual, emotional, social or behavioural development.

This should include cases where impairment is likely to be long-term, even if this is not immediately certain.

- There are 2 types of reviews:
  Local reviews – where safeguarding partners consider that a case raise issues of importance in relation to their area.
- **National reviews** – where the Child Safeguarding Practice Review Panel considers that a case raises issues which are complex or of national importance. The Panel may also commission reviews on any incident(s) or theme they think relevant.

In England, the key guidance for safeguarding practice reviews is Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children (Department for Education, 2018).

Ultimately, the decision to proceed to a review is always a local decision, for which local safeguarding partners are accountable. Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. Decisions on whether to undertake reviews should be made transparently and the rationale communicated appropriately, including to families.

As can be seen from the timeline below, Sefton LSCB have concluded and published 5 Serious Case Reviews between 2018 and 2020. These are those cases that met the Serious Case Review criteria as set out in governmental statutory guidance:

A serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Working Together to Safeguard Children 2015

	SCR1 (MARTHA, MARY & BEN)	SCR2 JANET	SCR3 CHARLIE	SCR4 MATILDA	SCR5 BEATRICE
Independent Author Appointed	February 2018	June 2018	July 2018	November 2018	July 2019
SCR Report to Sefton LSCB	July 2018	January 2019	February 2019	April 2019	February 2020
SCR report to National Panel	July 2018	February 2019	March 2019	October 2019	March 2020
SCR Publication	July 2018	April 2019 (sensitive delay due to anniversary)	March 2019	October 2019	March 2020

Sefton LSCB Review Process

All cases submitted to Sefton LSCB for review consideration are conducted in line with the policies and procedures. It is an expectation that Serious Case Reviews are completed within 6 months. The LSCB met this requirement in all of these cases. This process is governed by persons/people independent to any one organisation. The LSCB Business Manager who completes the Rapid Review* is Independent. The Chair of Sefton LSCB who makes the final decision is independent, as is the commissioned author of the report.

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

By way of transparency, all legal and statutory requirements to notify government departments of serious incidents are followed. This is a Local Authority requirement.

All of the SCR's are published and available to view on Sefton LSCB website www.seftonlscb.org.uk

Learning from Serious Case Reviews is also covered in Sefton LSCB annual report which is published and communicated to relevant forums. The annual report was presented to the Health and Wellbeing Board on 9 September 2020 and presented to the Corporate Parenting Board on 25 August 2020.

An open learning event for the whole multi-agency partnership was undertaken to share and disseminate the SCR learning. There was open invitation for elected members to attend as well as the working partnership.

Multi-agency 7-minute briefings are developed, shared and disseminated containing the key learning points from each Serious Case Review.

Learning from Serious Case Reviews are woven into all LSCB training programmes. From 2018 – present, Sefton LSCB has delivered 25 specific training courses (Working Together to Safeguard Children) to 539 practitioners. This specific course contains the learning from SCRs which is shared with delegates. Delivery of training during COVID19 has been challenging and Sefton LSCB has worked hard to develop virtual delivery to ensure the learning from SCRs continues to be a priority for Sefton LSCB to support continuous improved practice to ensure Sefton children are safeguarded.

Sefton LSCB Serious Incident//Rapid Review/Case Review Process

Incident - child dies or is seriously harmed and abuse or neglect is known or suspected

Within 5 working days of becoming aware of a serious incident, the Local Authority must notify the National Child Safeguarding Practice Review Panel and Sefton LSCB Business Unit.

Following notification received, the LSCB has 15 working days to undertake a Rapid Review of the case.

Day 1 – Sefton LSCB Business Unit notifies the Independent Chair, the LSCB Practice Review Group Chair, and begins the Rapid Review process

By Day 10 – LSCB Business Unit facilitates the Rapid Review with the three statutory Safeguarding Partners. The Business Manager presents the analysis of the rapid review to the panel of LSCB members who are selected to oversee the SCR to agree a decision on what type of review should be undertaken

By Day 12 – LSCB Business Manager submits the decision and initial recommendations to the Sefton LSCB Independent Chair

By Day 14 – LSCB Independent Chair makes their decision on the case. LSCB Business Unit notifies the National Child Safeguarding Practice Review Panel

Day 15 – LSCB Independent Chair's decision is fed back to the Chair of the standing sub group – (Practice Review Group) and the original referrer by the LSCB Business Manager.

Day 15 onwards – Once an independent author is identified, the LSCB Business Unit will inform the Child safeguarding Practice Review Panel (as required).

The National Child Safeguarding Practice Review Panel is sent a copy of the final Report at least seven working days before the date of publication.

What we have done as a result of the SCRs

- All relevant LSCB policies and procedures strengthened in light of the learning from the SCR's and other multi-agency reviews.
- Child Protection Standards amended to strengthen action planning expectations in relation to practice
- Early help practice standards have been introduced
- Neglect Strategy refreshed to include learning from SCR activity
- MASH Information Sharing Agreement approved and implemented
- LSCB have hugely increased practice resources on their website to support frontline staff. This includes all of the themes identified from the SCR's as well as complimentary resources in additional areas of safeguarding considerations
- Delivered partnership wide learning events (Hear My Voice) that reached over 1000 professionals. **See Sefton LSCB SCR Learning Event Newsletter**
  - *SCR learning events were delivered by a drama training company using the 'voice of the child' to disseminate the learning. There were 6 sessions delivered across 2 days (June & November 2019). There was open invitation for elected members to attend as well as the working partnership. Circa. 1000 practitioners from the children's workforce attended including a member of the Child Safeguarding Practice Review National Panel. Feedback was overwhelmingly positive about the events and the approach of the LSCB to learning.*
- The Level of Need Guidance has been refreshed and includes all themes of learning from these cases.
- The development of a bereavement strategy that provides advice and guidance for professionals.
- Representations to the Department of Health concerning the feasibility of developing and implementing a national IT system that provides greater connectivity between health professionals,
- Sought assurance from agencies that their information sharing policies are in place and include all cases, not just those that are managed under formal Child Protection procedures.

What remains outstanding?

Graded Care Profile 2 is being refreshed and relaunched and the LSCB has provided the finance for the licensed training requirements from the NSPCC which will fund an additional10 people to undertake the 'train the trainers' and become licenced to train others across the multi-agency partnership. The Graded Care Profile 2 (GCP2) is an updated, evidence based, practical tool that supports practitioners in measuring the quality of care delivered to a child or children over a period of time. The tool provides a representative view of the current level of care and provides grades for different aspects of care. The grades are based on good quality observations and good quality evidence in the family home.

The train the trainer is booked for 13 and 14 January 2021. Following this, there will be a plan in place for a full roll out and ongoing programme of training and support across the partnership. The aim is to have a team of 14 licensed trainers and GCP2 champions who are representative of the full partnership.

How we evidence improvements in practice as a result of this learning.

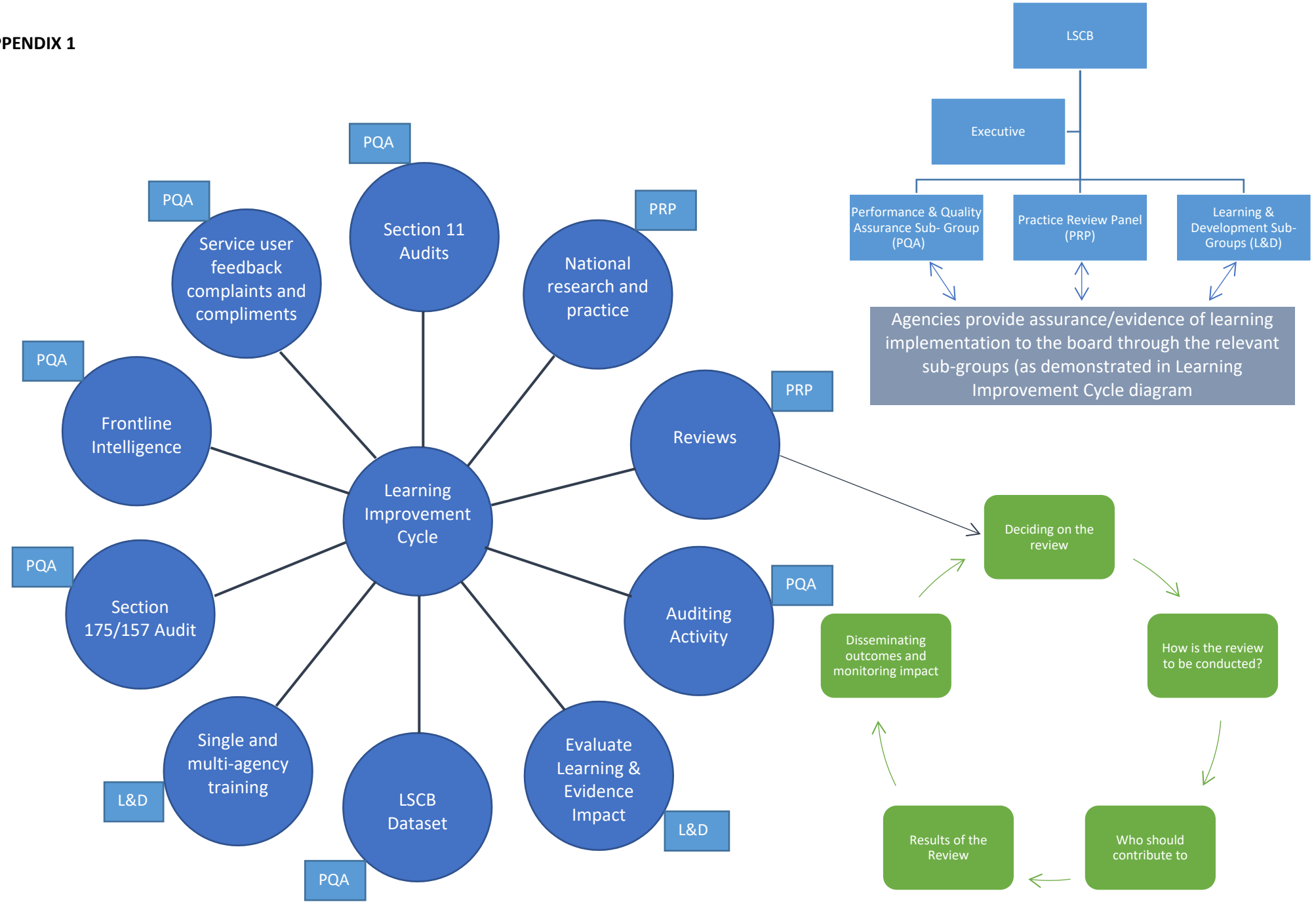
The LSCB seeks to capture improvements in practice through a variety of cyclical activities as illustrated in Appendix 1.

In conclusion

Sefton LSCB has concentrated its efforts to raise activity in relation to learning and practice improvements across a large and diverse partnership and this is evidenced in one way, through the transparency and communications of our case reviews. Whilst none of the SCR's concluded that any child death was preventable, there is always significant learning as a partnership to extract and this was the clear drive by the strategic leaders across the partnership.

Paula St Aubyn
Sefton LSCB Independent Chair
January 2021

APPENDIX 1


LSCB
Executive
Performance & Quality Assurance Sub- Group (PQA)
Practice Review Panel (PRP)
Learning & Development Sub-Groups (L&D)
Agencies provide assurance/evidence of learning implementation to the board through the relevant sub-groups (as demonstrated in Learning Improvement Cycle diagram
Learning Improvement Cycle
Section 11 Audits
PQA
National research and practice
PRP
Reviews
PRP
Auditing Activity
PQA
LSCB Dataset
PQA
Evaluate Learning & Evidence Impact
L&D
Single and multi-agency training
L&D
Section 175/157 Audit
PQA
Frontline Intelligence
PQA
Service user feedback complaints and compliments
PQA
Deciding on the review
How is the review to be conducted?
Who should contribute to
Results of the Review
Disseminating outcomes and monitoring impact