

Third report of the national panel of independent experts on Serious Case Reviews

November 2016

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National panel of independent experts on Serious Case Reviews

Introduction

1. *Working Together to Safeguard Children 2013*, the Government's guide to inter agency working published in March 2013, announced that a national panel of independent experts would be established 'to support Local Safeguarding Children Boards (LSCBs) in ensuring that appropriate action is taken to learn from serious incidents in all cases where the statutory criteria are met and to ensure that those lessons are shared through publication of final SCR reports.' The revised version of *Working Together*, published in March 2015, maintained the panel arrangements. This is the panel's third report.
2. In the period July 2015 to June 2016 there were 395 Serious Incident Notifications (SINs) to Ofsted, and the panel was advised of the initiation of 133 Serious Case Reviews (SCRs). During the same period in 2014-15, there were 326 SINs and the panel was advised of the initiation of 168 SCRs.
3. The panel met for the first time in June 2013 and works on a voluntary basis. It meets every month to consider submissions by LSCBs of notifiable incidents either where (i) there is no intention to initiate an SCR or (ii) there is a proposal that a completed report should not be published. In addition, during the reporting period it has met with the Association of Independent LSCB Chairs; with the Learning into Practice Project, which aimed to develop and pilot innovative ways to improve the quality and use of SCRs; and with Alan Wood as part of his review of the role and function of LSCBs.
4. The current panel has been appointed until June 2017 and has the following members:

Elizabeth Clarke is a practising barrister who has specialised in family law for over 20 years, having been called to the Bar in October 1991. She practises from Queen Elizabeth Building, Temple.

Nicholas Dann is Head of International Development at the Air Accidents Investigation Branch, the government body charged with the investigation of accidents and serious incidents to aircraft. He has over 10 years' experience as a senior inspector of air accidents during which time he has investigated a wide range of accidents, both in the UK and overseas.

Alice Miles is Director of Strategy and Advocacy at the Office of the Children's Commissioner. Alice was formerly a journalist and children's services policy adviser.

Peter Wanless became Chief Executive of the NSPCC in June 2013, joining from the Big Lottery Fund where he was Chief Executive for five years. Peter was previously a director at the Department for Education, specialising in schools' reform.

5. The panel thanks the secretariat provided by the Department for Education for its continued support.

Notifications

6. In the period July 2015 to June 2016, the panel has been advised of decisions to initiate 133 SCRs. It has considered a further 146 notifiable incidents reported to it where there has been a decision not to initiate an SCR (this figure includes 6 cases where an SCR has been stopped which have been classed as non-initiation). The panel agreed that, in 122 (84%) of these cases, an appropriate decision had been made. Of the remaining 24 cases, the relevant LSCB subsequently made 13 the subject of an SCR on receipt of the panel's advice, and four are awaiting further information. Of the remaining seven cases, the panel was satisfied in one case with the non-initiation decision after further information was provided and in the other six the LSCB did not accept the panel's advice, maintaining their original position¹.
7. Between July 2015 and June 2016, 101 of the 146 LSCBs contacted the panel. All LSCBs have now had contact with the panel in the period since July 2013.
8. The panel has continued to have to refer a number of cases back to LSCBs due to the failure to provide adequate information for a fully informed decision to be reached. It remains important that sufficient information on each case is provided to explain the circumstances and to support the argument for non-initiation.
9. The panel has also had cause on a number of occasions during this period to challenge what it considered to be misinterpretation of the criteria for the initiation of an SCR. This has included cases where abuse or neglect of a child is known or suspected and the child has died, and an LSCB has used the lack of concern about how agencies worked together to safeguard the child as a reason to not initiate an SCR. In such circumstances where a child has died, the way in which agencies worked together is irrelevant in terms of the criteria for initiation. The panel has also challenged decisions not to initiate an SCR because 'negligence, not neglect' was a factor, or because a child had suffered 'significant, but not serious' harm. In many of these cases, the panel finds the distinction somewhat arbitrary and has not accepted the differentiation.

¹ Where an LSCB does not accept the panel's advice about the initiation of an SCR, that decision is recorded and the panel itself can take no further action.

Period	SCR non-initiation decisions considered by panel	Non-initiation decisions agreed by panel	Non-initiation decisions challenged by panel	Non-initiation decisions reversed after panel challenge	Non-initiation subsequently agreed by panel after submission of further information	SCR non-initiation decisions upheld by LSCB despite panel's challenge
01/07/13 to 30/06/14	66	35 (53%)	31	8	20	3
01/07/14 to 30/06/15	107	88 (82%)	19	6	10	3
01/07/15 to 30/06/16	146	122 (84%)	20 ²	13	1	6

Table 1 – Non initiation decisions

Source: SCR panel secretariat

Publication

10. In the period July 2015 to June 2016, the panel received copies of 110 completed SCRs prior to publication. In addition, the panel considered 17 cases where a proposal had been made not to publish the final report. The panel agreed with four decisions not to publish, agreed to anonymous publication on the NSPCC website of three cases, and to the publication of only a summary in one case. Of the remaining nine cases where the panel disagreed with the LSCB's decision, one was subsequently published, three were not published and further information is awaited in five cases³.

Period	Completed SCRs received by panel	SCRs where panel considered case for non-publication	SCRs where panel agreed with case for non-publication	SCRs where panel disagreed with non-publication	SCRs where panel agreed to anonymous publication on NSPCC website	SCRs where panel agreed to a summary publication
01/07/13 to 30/06/14	74	7	4	0	2	1
01/07/14 to 30/06/15	80	16	8	4	3	1
01/07/15 to 30/06/16	110	17	4	9	3	1

Table 2 – Non publication decisions

Source: SCR panel secretariat

² Excludes four cases awaiting further information.

³ The panel cannot order publication of an SCR but can only advise.

11. Publication of SCRs is normally required to enable both professionals and the general public to understand what happened in cases where children have died or been seriously harmed, and why. Publication also allows for practice improvements to be identified and good practice to be disseminated. As currently set out in Working Together, SCRs must be written with the expectation that they will be published. Nonetheless, the panel understands that in exceptional cases there may be reasons why publication gives cause for concern. In such cases, the panel has requested the LSCB to provide expert, independent advice that publication represents a particular and serious threat to specific individuals before it will agree with a decision not to publish in full a completed report. There were four such cases in 2015-2016.
12. The panel does not under-estimate the sensitivity surrounding the publication of SCRs and has previously asked for evidence of cases where publication of an SCR has had direct and serious consequences. It has still to receive any such notification.

Concluding remarks

13. The Wood Report, a review of the role and functions of Local Safeguarding Children Boards commissioned by the Department for Education, was published in May 2016. The Report recommended the creation of a new national body to oversee a new national learning framework for inquiries into child deaths and cases where children have experienced serious harm, and to carry out reviews itself of such cases when it deems appropriate. The Government accepted this recommendation and, through the Children and Social Work Bill, is seeking to establish a Child Safeguarding Practice Review Panel. The Bill also sets out a requirement on local areas to establish new arrangements for safeguarding and promoting the welfare of children. These local arrangements will be responsible for commissioning reviews into cases not investigated by the new national Panel.
14. The panel believes that recommendations made in its previous reports will need to be considered as part of the new arrangements. It hopes that the new national Panel will be given sufficient resources and powers to enable it to be effective in fulfilling the complex functions with which it will be charged.
15. The panel is clear that it expects to continue to function as normal until such time as the new arrangements are put in place.

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