THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Child Safeguarding Practice Review Panel Webinar

August 2020

Welcome

Karen Manners QPM
10.00 – 10.10

First, who are we & what do we do?

System Oversight

maintain oversight of the system of national and local reviews and how effectively it is operating.

System Learning

identify and oversee the review of serious child safeguarding cases which, in our view, raise issues that are complex or of national importance.

System Leader

identify improvements to practice and protecting children from harm.

Reflections on Covid-19

- No discernible change to the overall number of notifications in March and April 2020
- May and June have seen increases in the overall number of notifications – as the numbers are small overall, we sometimes do see fluctuations
- Harm to babies – those under one – and older adolescents appears to be more prevalent than in other age groups

Reflections on Covid-19

- 19 rapid reviews (involving 20 children) where Covid-19 has been identified as relevant or influential in the serious harm or death of a child

- Themes include:
  - Mental health
  - Changing family dynamics
  - Stretched services

National Review Updates

Dale Simon
Peter Sidebotham
Mark Gurrey
10.10 – 10.30

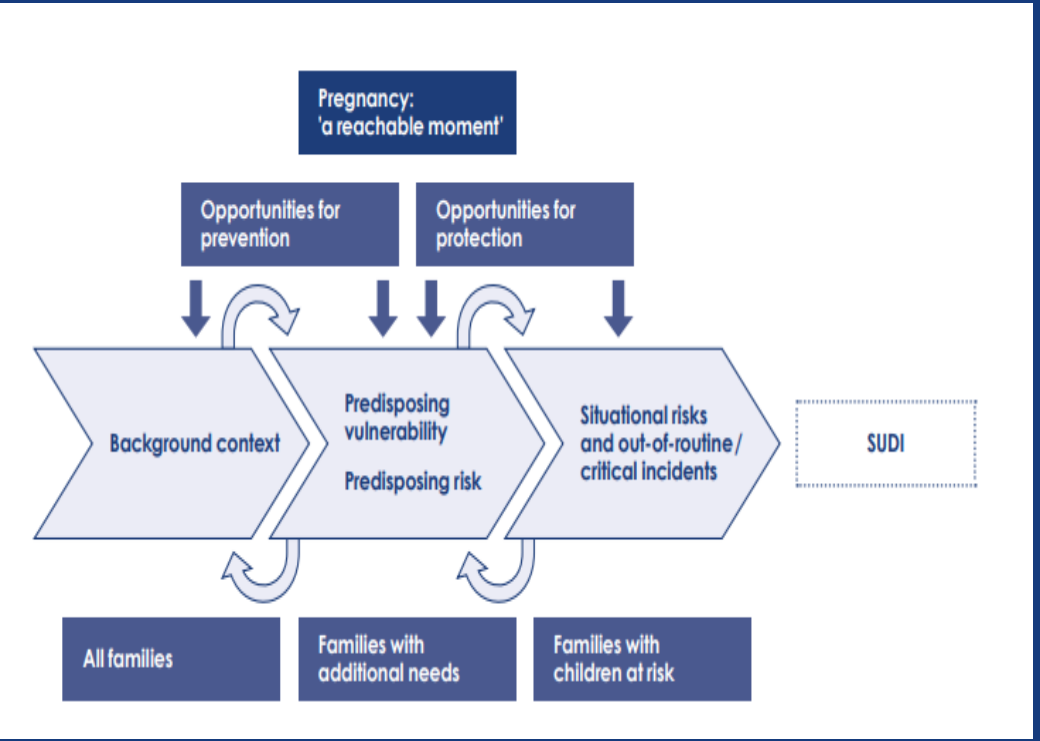
Safeguarding Adolescents at Risk of Criminal Exploitation

- Known risk factors around vulnerability don’t always act as predictors
- Moving children away from the local area isn’t an effective long-term solution to protect them from the reach of criminal gangs
- Exclusion from mainstream school can escalate the risk of manipulation by criminal networks
- Relationship based practice and making use of the reachable moment, such as arrests, school exclusion and physical injury, is critical for this group of children

Out of Routine:

Sudden Unexpected Death in Infancy (SUDI) Review

- Families with background vulnerability and risk
- Situational risks and out-of-routine / critical incidents
- Pregnancy as a ‘reachable moment’



A prevent and protect practice model

- Not just an issue for midwives and health visitors
- Flexible, tailored, relationship-based approaches
- Robust commissioning within wider strategies

- 3 national recommendations
- 2 research focus topics

Non-Accidental Injury in Under 1s

- We've announced our third national review will focus on non-accidental injury in babies under 1 year old.
- Since the Panel began, we have received 198 rapid reviews about babies and young children deliberately harmed or killed (29 June 2018 to 30 June 2020).
- Review will focus on both the backgrounds, motivation and psychology of men who have perpetrated violence and their too frequent absence from assessments and child protection planning
- The Fatherhood Institute has been appointed to undertake a literature review and the fieldwork is underway - three fieldwork reviewers and a clinical psychologist appointed

Review Q&A

10.30 – 10.45

Please submit your questions via the MeetingSphere forum

Local Child Safeguarding Practice Reviews

Mark Gurrey
10.45 – 11.10

Local Child Safeguarding Practice Reviews

Purpose is to

(i) Set out the Panel's thinking and expectations

(ii) Initiate a dialogue with Safeguarding Partnerships about :

- Criteria – led decision -making
- Nature of LCSPRs
- Alternative Reviews

Our Key Principles and Starting Points

- **Build on good practice we are seeing in a number of rapid reviews that have been thoughtful, reflective and sharply focused on learning**
- **Accelerate and truncate the timeline from incident(s) to analysis to dissemination of learning**
- **Generation of reviews that are timely, proportionate and focused on learning**
- **Learning has to be widely accessible - publication is key**

Working Together 2018

Criteria –Led

WT2018 is clear that:

‘When a serious incident becomes known to the safeguarding partners, 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.’

Criteria are met

LCSPR is commissioned

Independent Authors are identified; a Panel is constructed; IMRs are completed; a Combined Chronology is produced; a report is produced

Last Panel 3 LCSPRs were tabled – 2 referred to incidents in 2018 and took 12months to be completed and a further 9-10 months before publication. Averaged 33 pages

Sound familiar?

LCSPRs are NOT SCRs by any other name

So far, SPs have commissioned 79 LCSPRs and we have had 8 completed ones

Criteria are not met

Safeguarding Partners decide a further review is necessary/warranted/helpful and decide to do:

- **‘learning reviews’,**
- **‘multiagency reviews’,**
- **‘window on the system reviews’,**
- **‘practitioner workshops’**
- **or other locally defined processes.**

Criteria are not met

Examples:

Local safeguarding partners did not agree with the recommendation of the Rapid Review Panel because the criteria for serious harm was not met. Instead they suggested a Learning Review to focus on the events relating to the recent incident, including peer relationship difficulties and self harm.

Frontline and senior managers from agencies involved will take part in independently facilitated workshops to evaluate current approaches to families with complex needs and identify the barriers to effective multi-agency working, including information sharing

Our Position – 1

Meeting the criteria for a LCSPR is only the first question that needs to be answered. The second one is whether a further review is warranted taking into account the various considerations WT sets out

That when a further review is warranted, then that should always be labelled as an LCSPR regardless of the approach taken to complete it - the methodology should be chosen to best surface the issues to be explored

Those reviews should ensure they capture the views of both the practitioners and the family

Our Position - 2

That those reviews should be ‘proportionate’ by which we mean:

focussed on the core issues

not characterised by lengthy and detailed chronological reporting

major on identification and dissemination of learning

AND are then published

LCSPR Q&A

11.10 – 11.30

Please submit your questions via the MeetingSphere Forum

LCSPR Breakout

11.30 – 11.50

You will now automatically be split into groups for a breakout session

- Each group will have twenty minutes to discuss at least two of the topics
- Select a Facilitator to write down responses and feedback to the main group
- Capture your responses to the topics in Meeting Sphere
- You will automatically be returned to the main session at the end of 20 minutes

Breakout Topics:

1. *When your partnership is considering a further review, are you confident that there is a flexibility of approach and an identification of a methodology best suited to expose the issues within the case?*

2. *What might be the circumstances in your view when a review other than a LCSPR is warranted?*

3. *In what ways would an alternative review differ from a proportionate LCSPR?*

4. *Can you anticipate any difficulties in completing LCSPRs that adopt some of the different methodologies set out and still capture the voice of the practitioner and of the family?*

5. *Can you anticipate any difficulties in conducting LCSPRs using a range of methodologies and then making them available through publication to the wider safeguarding system in the country?*

Breakout Feedback

11.50 – 12.15

Groups feedback from their breakout discussions

Closing remarks

Karen Manners QPM
12.15 – 12.30

Please complete our post-event survey