Suffolk Safeguarding Children Board

www.suffolkscb.org.uk

**What are LSCB's?**

Local Safeguarding Children Boards (LSCB's) were established as part of the Children Act 2004. As a body they are not responsible for running child protection services but play an important role in challenging safeguarding practice and assessing the effectiveness of safeguarding services in their area.

Each local authority is required to set up an LSCB to bring together key agencies such as police, probation, health, education, youth justice and social care. The Chair of the LSCB is an experienced professional who is independent of the local agencies. In addition to coordinating and ensuring effectiveness of what is done by each agency to safeguard and promote the welfare of children, LSCB's also have a number of key things they must do which are set out in legislation.

These include agreeing local safeguarding policies and procedures for how different agencies work together, contributing to local plans, communicating and raising awareness of safeguarding to local organisations and the community, ensuring safeguarding training is provided and monitoring what the LSCB members do and how effective local safeguarding is. LSCB's are also required to ;

- Undertake serious Case Reviews (SCR's)
- Review the deaths of all children who are normally resident in the area; and
- Produce and publish and annual report on the effectiveness of safeguarding in the local area.

**What is a Serious Case Review?**

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of the LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in 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.

In addition, an SCR should always be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home, or where the child was detained under the Mental Health Act 2005. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide.

It is important to remember that the review is not a public enquiry, a disciplinary process or grievance hearing. The focus of the review has to be on how agencies worked together on the case to identify ways in which local practice might be improved in future.

**When does it start?**

A Decision to start an SCR is usually made within 1 month of the death or incident.

**How long do they take?**

It depends on many factors such as the scale and complexity of the case as well as other issues such as whether there are ongoing police investigations or criminal proceedings as in variably these have to be completed before SCR's can be finalised.

The target is to complete them within 6 months. Even if the review process has not been completed lessons to improve practice are usually identified at an early stage action commenced. It is important that any lessons that are learnt are implemented and shared at the earliest opportunity.

**Who writes the review? Is it just 1 person?**

There is usually an Independent Safeguarding Lead appointed to manage the process, chair meetings of the Review Team and facilitate the professional's learning events.

In addition an Overview Report Author is appointed with responsibility to write the final report and work closely with the Independent Safeguarding Lead to manage and lead the learning event meetings with professionals. In this particular case, the Overview Report Author lead the learning events and chaired the Review Team meetings.

**How are they chosen?**

In order to provide a totally independent view it is important that they are not from the local area and have no current relationship with either the LSCB or at local level any of the agencies involved in the case.

The Overview Report Author is usually someone with substantial experience as a practitioner and manager from one of the disciplines involved in child protection. There are no formal registers of individuals qualified to undertake this work so they tend to be chosen on reputation and through recommendation from other LSCB's who have been impressed with the quality of their work.

In practice, an Overview Report Writer is usually chosen because of their relevant experience, their availability to work within the timescale and their professional reputation.

The same is true of Independent Safeguarding Leads.

**Who was appointed in this case?**

The Independent Overview Writer for this case is Briony Ladbury RN, RM, HV cert, FP certificate, BA (hons) Protecting Children, ENB Specialist Practitioner award (Child Protection), MSc (Inter-professional Practice ( Society, Violence and Practice). She has a background in safeguarding children work in the NHS in strategic and practice contexts, producing and quality assuring NHS contributions to SCRs, and leading on developing NHS participation in SCRs for NHS England. She completed the taught modules for the Social Care Institute for Excellence Learning Together systems training in 2012 and undertook the DfE funded Course for Improving the Quality of Children's Serious Case Reviews in 2013. She is also trained in the NHS Root Cause Analysis approach.

Currently Briony Ladbury is working as an Independent Safeguarding Professional.

**What approach is used to conduct reviews and what was used in this case?**

Government Guidance entitled Working Together 2013 allows LSCB's to use any learning model consistent with the principles in the guidance, including systems based methodology. (An updated version of Working Together 2015 was published earlier this year, but the review in question was started under WT 2013)

After carefully considering the options it was decided to use a systems based partnership learning model. This model involved setting up a Review Team made up of senior managers from health, police and social care and each agency that had involvement in the case appointed a lead person to gather information and prepare a chronology of their involvement. Two learning events were then held attended by practitioners involved in the case and their line managers to help understand who did what and why, and to identify ways in which local practice should be improved. The Review Team met with the Independent Safeguarding Lead and Overview Author on three occasions to answer questions, initiate further enquiries and help shape the final report. Issues arising were acted upon by them and individual agencies as the learning unfolded.

**What are the potential outcomes of SCR's?**

The SCR identified a series of lessons that should be learned aimed at improving practice across and within agencies that work in Suffolk and Essex. The LSCB will

then decide what actions need to be taken to address the learning and decrease the likelihood of the same mistakes being made again in order to prevent other children being killed or harmed in the future.

**Are they legally binding?**

Neither the learning nor the actions arising are legally binding. They have the status of professional advice based on the experience of the case and analysis of the facts. It is for the constituent agencies of the LSCB to respond to this advice and review or amend where appropriate their operational policies, procedures and practice.

However, the actions are taken very seriously by the LSCB and many in this case are designed specifically to ensure that changes have been made to single agency practice and that those changes are having the desired impact.

In addition the LSCB is itself subject to external scrutiny and is held accountable by government through Ofsted.

**Could SCR's lead to disciplinary action, dismissal or further legal proceedings?**

SCR's do not in themselves lead to disciplinary action, dismissal or further legal proceedings. An SCR does not recommend action against an individual; it seeks to look at how the whole system can be improved to protect children from harm.

However, the findings of the SCR may be used in subsequent actions by individual agencies after it becomes a public document.

**Once an SCR is published what happens?**

The LSCB have responded to the SCR by agreeing a range of actions that should be taken to address the learning. This is transferred into an Action Plan, the progress against which the Suffolk LSCB Learning and Improvement Group will monitor until they are all in place.

This process is not always a quick fix and can sometimes take anything up to 2 years depending on the nature of the actions. Progress is regularly reported to the LSCB and if there are difficulties in achieving particular actions then the Board has a responsibility to challenge those partners to ensure agreed actions have been taken and changes implemented.