Leeds Safeguarding Children Partnership

Report to: Leeds Children and Families Scrutiny Board
Report from: Leeds Safeguarding Children Partnership Executive
Title of Report: LSCP Notification Process
Date: 8 March 2022

1. Purpose of report

1.1. This report sets out to update the Children and Families Scrutiny Board, on progress following the review of the notification process commissioned by the LSCP Executive, and the collective decisions reached with regards to decision making in relation to Serious Child Safeguarding Incidents (SCSI).

2. Introduction

2.1. Working Together to Safeguard Children 2018 (WTSC) Guidance, which underpins the legislative framework of the Children Act 2004 and the associated regulations, states that *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*[1]

2.2. The guidance also adds that *the duty to notify events to the Panel rests with the local authority*[2] and the LSCP Executive have sought legal advice on this position. By way of confirmation the legal advisor to the Leeds Safeguarding Childrens Partnership (who is employed by the local authority) has advised that the Children Act 2004 confers upon a local authority the function of making a notification. This function is a duty rather than a power, and in exercising this function a local authority is required to determine whether a case meets the statutory criteria for a notification[3], or not. In doing so it has to make a decision, having regard to public law principles including, but not limited to, applying the statutory criteria, taking into account all relevant information, and ignoring irrelevant considerations.

2.3. Furthermore, that in making that decision it is an integral part of the decision-making process that they are informed and guided by the views of statutory partners. However, the ultimate responsibility to notify, or not to notify, lies with the local authority, as set out in legislation. There are no provisions within the legislation which permit a local authority to delegate this statutory duty to partners. The local authority remains accountable in law for the decisions made.

2.4. The LSCP Independent Chair informed the LSCP Executive in July 2021 that she was not assured about the notification systems in Leeds, this was informed by a serious case raised to the Review Advisory Group (RAG)[4] that had not been notified to the National Child Safeguarding Practice Review Panel. This led the LSCP Independent

[1] Working Together to Safeguard Children 2018, Chapter 4.7
[2] Working Together to Safeguard Children 2018, Chapter 4.14
[3] A serious child safeguarding case as defined by Working Together to Safeguard Children 2018 is one whereby abuse or neglect of a child is known or suspected and the child has died or been seriously harmed.
[4] The LSCP RAG is composed of representatives for the three key Statutory Safeguarding Partners Local Authority, Health, and Police.

Chair to recommend a review of this process which was approved by the LSCP Executive and was undertaken by a group consisting of representatives from each of the three key statutory partner agencies and led by West Yorkshire Police.

2.5. The LSCP Executive has provided an overview with regards to the progress of the Review and the key issue of decision making in relation to a SCSI to the Leeds Children and Families Scrutiny Board, with the last being in May 2022.

3. Summary of progress since May 2022 and decisions made

3.1. The Review identified areas of improvement in relation to the forms and templates used when considering a potential SCSI and made further recommendations relating to the SCSI review process.

3.2. These recommendations and improvements have been accepted by the LSCP Executive and are now being embedded into practice:

- A Partnership Serious Child Safeguarding Incident Notification Discussion form has been developed to allow all partner agencies to raise cases with the RAG which it believes may meet the criteria for notification in a consistent way. The RAG has representatives from the three key statutory partners, health, police, local authority, alongside the Independent Chair of the LSCP and LSCP Business Unit Managers. The form, which is submitted to the LSCP Business Unit, ensures that cases which are raised are done so in line with the notification criteria and that partners are able to provide their rationale for referral. The form allows identification that the referral has been undertaken in discussion and agreement with the referrer's agency safeguarding lead (or RAG representative where applicable)
- The form has a section to record the RAG's discussion in relation to whether or not the criteria for notification is met, including the outcome of the discussion, any areas of disagreement and next steps. If a notification is to be made there is a section to record that this has occurred.
- A system has been developed within the LSCP Business Unit which records all referrals for consideration of a notification, key details of the incident, outcome, and next steps.
- On receipt of each referral the LSCP Business Unit circulates the Partnership Serious Child Safeguarding Incident Notification Discussion form to the RAG and an Extra-ordinary RAG meeting is held to consider the information known to all agencies at that point in time. This is an opportunity for RAG members to share information and provide their professional views with regards to the notification criteria.
- Where a child has died the LSCP Business Manager will attend the statutory Sudden Unexpected Death in Childhood[5] (SUDIC) meeting and feed any additional or relevant information into the RAG meeting for consideration.
- When the decision of the Children and Families directorate is not to notify, and there is disagreement with one or more RAG partners, the rationale for this is provided by the Children and Families directorate in writing to all RAG members within the 5-day notification timescale[6]. This is then shared with the LSCP Executive for noting.

[5] The Royal College of Paediatrics and Child Health-Sudden unexpected death in infancy and childhood - 2016
[6] Working Together 2018 states that all notifications to the National Child Safeguarding Practice Review Panel must be made within 5 working days of the local authority being made aware of the incident

- If a notification is made and a Rapid Review[7] held, partner agency scoping authors[8] have been invited to participate within the Rapid Review, presenting their reports and considering learning. This has led to richer conversations and extraction of learning due to representation from those agencies working closely with the child / family. In some instances this has avoided the need for a local Child Safeguarding Practice Review (CSPR) as the Rapid Review has led to robust and timely learning.

3.3. This has effectively simplified the process to support any partner agency wishing to refer a potential SCSI to the LSCP RAG and enhanced the process which ensures all referrals are carefully considered in a multi-agency forum with decision making being informed by information, knowledge, and professional expertise from all three statutory partners. This process has been rigorously tested using cases referred into the RAG and agencies have expressed their full confidence that this process is robust.

3.4. With respect to the decision as to whether a SCSI is notified to the National Safeguarding Practice Review Panel, the Executive have considered the options presented within the paper to the Leeds Children and Families Scrutiny Board in May 2022, namely:

Option 1

To continue following the current process where, the Local Authority has the duty to consider and decide whether a case meets the criteria for notification to the National Safeguarding Practice Review Panel, even if there are differences of opinion amongst partners.

Option 2

To consider a system whereby if the LSCP Executive cannot agree whether a case meets the criteria for notification to the National Safeguarding Practice Review Panel then the LSCP Independent Chair will request the LSCP Executive to vote. The Local Authority will then take forward the majority view to notify a case to the National Safeguarding Practice Review Panel. This option goes against the legal advice given by the LSCP Legal Advisor, that this is unlawful, and that the LSCP Executive may wish to seek further independent legal advice.

Option 3

If no consensus, then the Local Authority maintain their position on notification but write to the National Safeguarding Practice Review Panel, LSCP Exec, Exec Lead for Children and Families and Scrutiny Chair with a rationale for the decision and commitment to initiate a learning process agreed by the LSCP Executive. The Local Authority recognises that there may be cases where a consensus is not reached by the Review Advisory Group and LSCP Executive as regards significant or serious harm. Where this decision is very finely balanced there may be cases where the Local Authority will take account of the majority views of the other two statutory partners and make the decision to notify however, this cannot be a blanket approach.

3.5. In July 2022 the LSCP Executive agreed that it will not seek further legal advice with regards to this matter[9], and acknowledged that the legal advice from the LSCP legal

[7] The statutory multi-agency review process following a notification of a SCSI. All partner agencies are scoped with regards to their contact with the child and family and this information is reviewed in order to identify areas of good practice and learning. Following a Rapid Review a decision is made as to whether a Child Safeguarding Practice Review is required to further extrapolate learning, and an Action Plan developed with regards to any identified learning.
[8] Scoping authors are senior safeguarding leads in partner agencies who have responsibility to provide information on their agency involvement on each case
[9] Legal advice has been provided by the LSCP Legal Advisor (LCC Legal and Democratic Services legal representative) and West Yorkshire Police Legal Services

advisor meant that Option 2 is not a possibility for the Local Authority. Police and Health partners are not in agreement with Working Together 2018 placing the duty to notify with a single agency, as this does not represent a position of equal decision making. However on the basis of the improvements in discussions and the wish not to seek further legal advice the LSCP Executive have agreed to adopt Option 1.

3.6. The LSCP Executive have acknowledged that the changes in processes as described above have resulted in a more equitable approach to decision making and partners report that they are able to more effectively contribute to the decision-making process. Notifications to the National Safeguarding Practice Review Panel have increased and decisions made in relation to 100% of cases have been unanimously agreed by RAG members. This enhanced process of open, honest, and robust discussions along with appropriate challenge is now recognised by all partners.

3.7. It has been agreed that where there is disagreement in relation to decision making, the rationale for the decision will be provided in writing to all RAG members by the Local Authority within the five-day notification timescale. This will then be provided to the LSCP Executive for noting.

3.8. A workshop with the LSCP Executive, the Chair of the National Safeguarding Practice Review Panel and the three National Safeguarding Reforms Facilitators for Health, Police and Local Authorities took place in May 2022. It was highlighted at this meeting that Working Together to Safeguard Children 2018 will be updated within the next 12-18 months and that it would be beneficial to share our journey in Leeds in order to feed into the update with respect to guidance around SCSIs and associated review processes.

3.9. Feedback based on the Leeds journey has been fed into a recent consultation on the update of the National Safeguarding Practice Review Panel guidance which was updated in September 2022[10].

3.10. The updated process has been shared with partner agencies.

4. Next Steps

4.1. This interim process in line with Option 1 will be monitored by the LSCP Executive and reviewed after 12 months (July 2023).

4.2. The LSCP Executive are considering how to feed their experience and views into the anticipated update of Working Together to Safeguard Children 2018. The LSCP Independent Chair has written to Brendan Clarke-Smith MP with regards to this matter and offered to share her views as to how the guidance could be strengthened in relation to this area.

4.3. In addition to the area of decision making in relation to SCSI notifications, the review has identified further areas of learning and enhancements, namely:

- Enhancing the dissemination of learning both multi-agency and internally within partner agencies
- Enhancing oversight and quality assurance of action plans resulting from Rapid Review or Child Safeguarding Practice Reviews in order to identify impact on practice and outcomes for children and young people

[10] Child Safeguarding Practice Review Panel guidance for safeguarding partners

- Considering capacity within the LSCP Business Unit in relation to Rapid Reviews, learning and monitoring the implementation and impact from all local learning.

A work plan is being developed to address these and will be implemented and monitored through the Leeds Children and Young People Partnership.