Independent safeguarding review commissioning guide

Scope, commission and govern an independent review that produces credible learning, accountable action and demonstrable safeguarding improvement.

Introduction

An independent safeguarding review is a structured process for examining how an organisation has responded to safeguarding concerns, incidents or patterns of practice, and identifying what can be learned and improved.

For commissioners and safeguarding leaders, the value of an independent review is not simply the production of a report. It is the assurance that the review is appropriately scoped, genuinely independent, well governed and capable of producing meaningful improvements in safeguarding practice.

This guide explains what to consider before commissioning a review, what the process normally involves, what you should expect to receive, and how your organisation should respond to the findings.

> **The commissioning principle**
> *A credible review should produce learning that leads to accountable action and demonstrable improvement.*

1 What is an independent safeguarding review?

An independent safeguarding review is an external examination of safeguarding practice undertaken by someone who is sufficiently independent from the organisation, service or incident being reviewed.

The purpose is usually to:

- establish what happened and how decisions were made;
- examine the effectiveness of safeguarding arrangements and practice;
- identify strengths as well as weaknesses;
- understand the factors that contributed to the situation;
- identify learning for individuals, teams, leaders and the wider organisation;
- make practical recommendations for improvement; and
- provide assurance to governance bodies, commissioners, partners or regulators where appropriate.

An independent review should be proportionate to the circumstances. It is not automatically an investigation, disciplinary process, complaint investigation or regulatory inspection. Depending on the circumstances, it may sit alongside these processes, but its purpose and methodology should be clearly defined.

2 When might an organisation commission one?

An independent review may be appropriate following:

- a serious safeguarding incident or allegation;
- concerns about the effectiveness of safeguarding arrangements;
- repeated or escalating safeguarding concerns;
- significant weaknesses identified through audit, inspection or assurance activity;
- concerns about leadership, governance or organisational culture;
- a complex case involving multiple services or agencies;
- a case where internal review would not provide sufficient independence;
- concerns raised by staff, service users, families, commissioners or partners; or
- a need to test whether previous safeguarding improvements have been embedded.

> **i** **Remember**
> *Commissioning an independent review does not necessarily mean that an organisation has failed. It can demonstrate a commitment to openness, learning and continuous improvement.*

3 Define the scope before commissioning

A clear scope is one of the most important commissioning decisions. The terms of reference should explain what the review is intended to establish and what is outside its remit.

Case or incident

- What events, concerns or period of practice are being reviewed?
- What is the relevant timeframe?
- Are there particular decisions, referrals, assessments or interventions that require examination?

Practice

- How effective were safeguarding identification, assessment, escalation and response?
- Were policies and procedures followed and, if not, why not?
- Were professional judgements reasonable based on the information available at the time?

Systems

- Were staffing, supervision, training and resources adequate?
- Were information-sharing arrangements effective?
- Did organisational processes support good safeguarding practice?
- Were there barriers that affected staff decision-making?

Leadership and governance

- Was safeguarding appropriately overseen?
- Were risks escalated through the appropriate governance routes?
- Did leaders receive accurate and timely information?
- Were previous recommendations acted upon?

Voice and experience

- How were the views, wishes and experiences of the child, adult, family, carer or other relevant people considered?
- Were people appropriately involved in safeguarding decisions affecting them?

Avoid an excessively broad scope

A review can lose effectiveness if it attempts to examine every aspect of an organisation. A focused scope makes it easier to distinguish what happened, why it happened, what should change and how change will be evidenced.

The terms of reference should also identify any related investigations or processes so that the reviewer understands how their work fits within the wider governance picture.

4 What does 'independent' mean?

Independence is more than using an external consultant. The reviewer should be able to reach conclusions without inappropriate influence from the organisation commissioning the work or from people whose decisions are being examined.

Before appointment, consider:

- previous work undertaken for the organisation;
- personal or professional relationships with people involved;
- financial or commercial interests;
- involvement in the events under review;
- whether the reviewer has an appropriate safeguarding background;
- whether they have experience conducting independent reviews; and
- whether they can demonstrate impartiality.

The commissioner should not predetermine the findings. It is reasonable to agree the scope, methodology, timescale, reporting arrangements and governance process. It is not appropriate to direct the reviewer towards a particular conclusion.

Independence should be visible

The final report should make clear:

- who commissioned the review and who conducted it;
- the reviewer's relevant expertise;
- the scope and methodology;
- any relevant limitations or conflicts of interest; and
- how the reviewer maintained independence.

5 Selecting the reviewer

The reviewer should have the right combination of safeguarding expertise, analytical ability and independence.

Depending on the subject, you may need expertise in areas such as:

- safeguarding practice; leadership and governance; social care; health; education;
- policing or criminal justice; mental capacity and consent; organisational culture;
- information governance; or multi-agency working.

When commissioning, ask potential reviewers to demonstrate:

- relevant professional experience and experience of comparable reviews;
- their proposed methodology and how they manage conflicts of interest;
- how they involve people with lived experience where appropriate;
- how they distinguish evidence from opinion;
- how they develop recommendations; and
- how they assess whether recommendations are likely to be achievable.

> **What to look for**
> *A strong reviewer should be willing to challenge the organisation constructively rather than simply confirm its existing narrative.*

6 Governance arrangements

The review should have clear governance from the outset. Agree:

- who is the commissioning lead and who approves the terms of reference;
- who receives progress updates and the final report;
- how conflicts of interest and confidential information will be managed;
- how staff and other participants will be supported;
- how emerging risks will be escalated; and
- who is responsible for implementing recommendations.

The organisation should also agree what happens if the reviewer identifies an immediate safeguarding concern during the review. The review must not become a reason to delay action where a current person may be at risk.

> **i** **Governance principle**
> *The reviewer provides independent findings and recommendations. The organisation remains responsible for safeguarding people, responding to risk and implementing improvement.*

7 What evidence might the reviewer examine?

The precise evidence will depend on the scope, but may include:

- safeguarding policies and procedures; case records and chronology; referral and escalation records;
- assessments and care plans; meeting and supervision records; training and competency information;
- staffing information; audit and quality-assurance findings; complaints, concerns and whistleblowing information;
- previous safeguarding reviews; board or committee papers; governance reports and risk registers;
- relevant correspondence; interviews with staff and leaders;
- conversations with people who use services and families; and information from partner organisations.

The reviewer should explain how evidence was selected and assessed. A review should avoid hindsight bias. Decisions should generally be considered in the context of the information, circumstances and pressures available to those making them at the time.

8 Interviews and participation

Interviews are often central to an independent review. Participants may include frontline practitioners, safeguarding leads, managers, senior leaders, board or committee members, partner agencies, family members or carers, and people directly affected by the safeguarding response.

Participants should understand:

- why the review is taking place and the purpose of the interview;
- how information will be used and any limits to confidentiality;
- whether their contribution may be identifiable in the report; and
- what support is available if discussing the events is difficult.

Where appropriate, the review should seek the perspectives of people with lived experience. Their voice should not be treated as an optional addition: it can be essential to understanding the effectiveness and impact of safeguarding practice.

9 How findings should be developed

A good independent review goes beyond identifying what went wrong. The reviewer should examine the underlying causes and contributing factors.

> **i** **Example finding**
> *A safeguarding concern was not escalated promptly.*

A useful review should ask:

- What information was available, who knew about it and what did they understand the risk to be?
- What policy or process applied, and was the process clear?
- Did staff have appropriate training and was supervision available?
- Were workload, staffing, communication or information-sharing factors relevant?
- Did organisational culture affect escalation?
- Had similar concerns occurred previously, and were warning signs visible at governance level?

This moves the review from 'who made the mistake?' towards 'what needs to change to reduce the likelihood of recurrence?' That does not remove individual accountability where appropriate. It places accountability within a broader learning and systems context.

10 What should the final report contain?

Executive summary

A concise overview of the circumstances, key findings and principal recommendations.

Background and context

Relevant information about the organisation, service, incident or case.

Scope and terms of reference

What was examined and what was outside the review.

Methodology

How evidence was gathered and analysed, including interviews and document review.

Chronology

A clear account of significant events where this helps explain the findings.

Findings

Evidence-based conclusions addressing the questions in the terms of reference.

Good practice

What worked well and should be retained or replicated.

Learning

What the organisation and relevant partners can learn from the findings.

Recommendations

Specific actions addressing the identified issues.

Limitations

Any gaps in evidence, unavailable records, participants who could not be interviewed or other factors that affect interpretation.

11 What makes a good recommendation?

Recommendations should be:

- specific; proportionate; achievable;
- assigned to an accountable owner;
- time-bound where appropriate; measurable; and
- connected to the evidence and findings.

> **i** **Avoid**
> '*Staff should receive more training.*'

A stronger recommendation would identify what competency needs to improve, who requires it, how it will be delivered and how the organisation will demonstrate that practice has changed. The objective is not to produce a long action list. It is to identify the changes most likely to improve safeguarding.

12 How should your organisation respond?

1. Acknowledge the findings

Senior leaders and the relevant governance body should formally receive the report and understand the implications.

2. Protect immediate safety

Address any current safeguarding risks without waiting for the full improvement programme.

3. Develop an action plan

Translate recommendations into clear actions with an accountable owner, milestones, completion dates, required resources and measures of success.

4. Communicate appropriately

Explain the findings and resulting actions to relevant staff, partners, people who use services and families, while respecting confidentiality and data-protection requirements.

5. Test whether change has occurred

Do not treat completion of an action as proof of improvement. Use audits, supervision, case sampling, feedback, performance information and other assurance mechanisms to test impact.

6. Report progress through governance

Progress should be visible to the appropriate board, safeguarding committee, trustees, commissioners or other oversight body.

7. Revisit recommendations

Where an action is no longer appropriate, has failed to deliver improvement or requires modification, explain why and agree an alternative approach.

13 Commissioning checklist

Before commissioning

- Define the purpose and intended outcomes; agree a proportionate scope; identify related investigations or reviews.
- Establish governance arrangements; identify and manage conflicts of interest.
- Assess potential reviewers' independence and expertise; agree methodology and evidence requirements.
- Consider how people with lived experience will contribute.
- Agree information-sharing, confidentiality and urgent-risk escalation arrangements.
- Set realistic timescales and agree reporting arrangements.

When receiving the report

- Confirm that the report addresses the agreed terms of reference.
- Consider whether findings are evidence-based and sufficiently clear.
- Identify immediate safeguarding risks; agree recommendations and accountable owners.
- Develop an improvement plan and establish measures of impact.
- Communicate appropriately, schedule governance oversight and plan follow-up assurance.

14 Key questions for commissioners

Focus	Question
Scope	Does the proposed scope answer the safeguarding questions that actually matter?
Independence	Would a reasonable person regard the reviewer as sufficiently independent?
Methodology	Will the reviewer examine both individual practice and the organisational factors that shaped it?
Voice	How will the experience of the person affected by safeguarding be understood?
Governance	Who will receive the findings, and who has authority to act on them?
Recommendations	Will recommendations be specific enough to drive measurable improvement?
Impact	How will we know that the review has changed practice rather than simply generated an action plan?

15 The commissioning principle

The strongest independent safeguarding reviews are not exercises in assigning blame or producing a report for its own sake.

They provide a disciplined way to ask:

- What happened, and what influenced what happened?
- What did we do well, and what should have been different?
- What needs to change?
- How will we know the change has improved safeguarding?

For commissioners, the critical test is not simply whether an independent review has been completed. It is whether the review has generated credible learning, accountable action and demonstrable improvement in safeguarding practice.

Important information