Framework and Practice Guidance

Local Child Safeguarding Practice Reviews

Including Serious Incident Notifications and Rapid Review

NCASP
NORTHUMBERLAND CHILDREN AND ADULTS SAFEGUARDING PARTNERSHIP

March 2023

Contents

1. Who is the Guidance for?

This framework and practice guidance should be adhered to by all partner agencies of the Safeguarding Partnership.

The guidance is particularly aimed at those involved in undertaking or contributing to Local Child Safeguarding Practice Reviews (LCSPRs), such as the three key statutory safeguarding partners (*Northumberland County Council, North East North Cumbria Integrated Care Board and Northumbria Police*), Independent Lead Reviewers, Safeguarding Practice Review Group (SPRG) and panel members, those providing information reports on behalf of their organisation as well as those responsible for quality assuring and embedding the learning from the review process.

2. About this Framework

This framework should be read alongside the relevant statutory guidance for conducting CSPRs as set out in Chapter 4: Improving child protection and safeguarding practice (WT2018) and the Child Safeguarding Practice Review Panel guidance for safeguarding partners

The framework has been endorsed by safeguarding partners in Northumberland. The framework will be reviewed and updated to reflect changes in national guidance and emerging good practice.

In the event of a child death, this framework must be read alongside the Child Death Review operational guidance. Although information gathering can be commenced for the Child Death Overview Process, any Rapid Review or CSPR must be concluded prior to consideration or conclusion at the Child Death Overview Panel.

3. Introduction and Context

Responsibility for how a system learns lessons from serious child safeguarding incidents rests at a national level with the Child Safeguarding Practice Review Panel (the National Panel) and at a local level with the three Safeguarding Partners (integrated care board, police and local authorities).

This framework outlines a shared process for commissioning and undertaking Local Child Safeguarding Practice Reviews (LCSPR) in Northumberland.

The framework describes the approach, order of events and related timescales expected to facilitate an effective CSPR whilst also highlighting the key statutory elements outlined in Working Together to Safeguard Children 2018. It outlines responsibilities for stakeholders at every stage of the process and includes template documents and letters.

The guidance and template documents / letters should not, however, be seen as a prescriptive approach. Instead, this framework and guidance should be used as a toolkit to help choose the most appropriate methodology for each individual case.

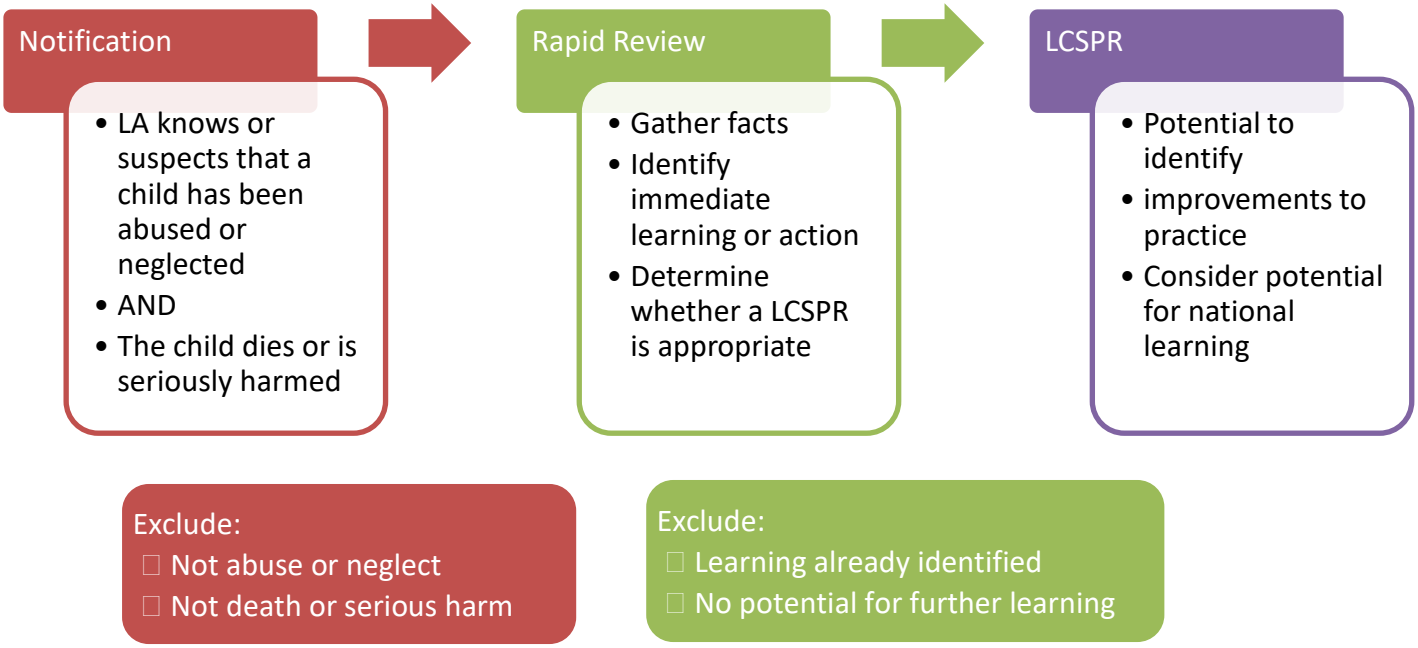
4. Decision making around reviews

As outlined in Working Together 2018, there are three key stages in the process of learning from serious cases (Figure 1):

- Serious Incident Notification to the Panel (shared with Ofsted and the DfE)
- Rapid review

• Local Child Safeguarding Practice Review (LCSPR)

Figure 1: Decision making around reviews



While the responsibility for notification rests with the local authority, once a case has been notified, responsibility for the rapid review rests with the three safeguarding partners. Good practice suggests that the local authority should wherever possible consult with other safeguarding partners when deciding whether to notify.

Decisions around whether to proceed to an LCSPR, and the recommendations and action plans arising from rapid reviews and LCSPRs need to be agreed by senior representatives of each of the three partners. Where responsibility is delegated within the partner agencies, those holding responsibility need to be clearly identified, have the authority to make decisions on behalf of their agency, and have clear lines of accountability.

5. Identification and notification of a serious child safeguarding incident

Notification of serious incidents

Section 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) states:

Where a local authority in England ***knows or suspects that a child has been abused or neglected***, the local authority must notify the Child Safeguarding Practice Review Panel if

a. The child dies or is seriously harmed in the local authority's area; or
b. While normally resident in the local authority's area, the child dies or is seriously harmed outside England.

The local authority must notify any event that meets the above criteria to the Panel. They should do so within ***five working days*** of becoming aware that the incident has occurred. The local authority should also report the event to the safeguarding partners in their area (and in other areas if appropriate) within five working days.

The local authority must also notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected.

The duty to notify serious incidents to the Panel sits with local authorities. All notifications are also made available to the DfE and Ofsted.

The CSPR Panel expect local authorities to have in place effective systems for the timely notification of all incidents in their areas meeting the notification criteria set out in Working Together 2018. This also includes ensuring that sufficient staff are registered and available to submit online notifications using the DfE's Child Safeguarding Incident Notification System and there are appropriate local failsafe processes to track originating information to inform notification.

As outlined in Working Together 2018, cases should be notified within five working days of the local authority becoming aware of the incident.

It is CSPR Panel's expectation that any case which is subject to a rapid review should have been notified to the Panel. If the Panel receives a rapid review for a case which has not been notified, we will ask the local authority to submit a notification.

Responsibility for deciding whether to notify

Where an agency other than the local authority becomes aware of an incident that appears to meet the criteria for notification, they should discuss this with their local authority counterparts to reach an agreement on whether or not to notify.

There may be instances where safeguarding partners do not initially agree on whether there is a need to notify the Panel following a serious incident. For instance, it may be unclear whether an incident appears to have met the criteria for notification. Discussion between safeguarding partners about cases and the decision to notify is crucial. Strong partnership working is predicated on collaboration and open dialogue.

Where agreement cannot be reached through dialogue between the safeguarding partners alone, the support of appointed independent scrutineers could help resolve differences. Ultimately however, the final decision on whether or not to submit a notification to the Panel following an incident is the responsibility of the local authority. This is clearly set out in Working Together 2018 and while the CSPR Panel can offer advice where appropriate, they cannot mediate or resolve differences between safeguarding partners.

Is it abuse or neglect? is it serious?
The Child Safeguarding Practice Review Panel guidance for safeguarding partners provides further help and clarity, including specific examples and thematic learning to support consideration for notification.

IDENTIFICATION

- Serious child safeguarding case is identified by a professional i.e. abuse or neglect of a child is known or suspected, **and** the child has died or been seriously harmed.
- The professional discusses the case with their safeguarding lead/senior manager who consults with a safeguarding partner representative (if possible). Agency assessment is that the definition of a serious child safeguarding incident is met.

NOTIFICATION

- **As soon as possible after the child's death or incident of serious harm**
- The professional (with the support of their safeguarding lead/senior manager as appropriate) notifies the NCASP Business Manager (and chair of SPRG) of any serious incident which they have assessed meets the criteria be considered for a LCSPR.

6. Rapid reviews

Safeguarding partners are required to promptly undertake a rapid review on all notified serious incidents.

A flow chart setting out the key stages and suggested timescales is included at the end of this section – see Rapid Review Process - These timescales are indicative only and individual areas may choose to adapt the timescales to ensure completion of the Rapid Review within the required 15 working days.

Where an incident has not been notified and does not meet the criteria for notification, there is no requirement to send a rapid review to the Panel.

Rapid reviews should identify, collate, and reflect on the facts of the case as quickly as possible in order to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning.

- For safeguarding partners, the rapid review should conclude with a decision about whether or not an LCSPR should be commissioned using the criteria set out in Working Together 2018.
- If the decision is to commission an LCSPR, the key lines of enquiry and the questions that are to be answered by the review process should be set out in the conclusion to the rapid review.
- Good practice is where partnerships identify what has been learnt and how this learning will be disseminated and acted on across the local partnership.

Advice on conducting rapid reviews

Ultimately what is most important is that safeguarding partners identify and act on learning which is useful to them.

A well-conducted rapid review can form the basis of an LCSPR and, in some cases, may avoid the need for an additional lengthy review which may result in only limited additional learning. However, where a case is particularly complex, or the potential for further learning is identified, a rapid review, carried out within tight time constraints, cannot replace the rigour and transparency of an LCSPR.

We do ask as a minimum that the rapid review records:

- Date of birth, gender and ethnicity of the child who has been harmed or who has died and whether the child had any known disability
- Family structure and relevant background information on the family – include all children not just the one(s) harmed or who died. A family tree (genogram) is often helpful. Relevant information should be provided on the parents and any significant adults, including ages and any known physical or mental health problems or disability.
- Immediate safeguarding arrangements of any children involved;
- A concise summary of the facts, so far as they can be ascertained, about the serious incident and relevant context;
- A clear decision as to whether the criteria for a local child safeguarding practice review have been met and on what grounds, and if not, why not. Clear reasons are required;
- Any immediate learning already established and plans for their dissemination;
- Which agencies have been involved in the rapid review, explaining any agency omission whose involvement would be usually expected;

Important issues to consider in rapid reviews:

- What was the child's true lived experience and how can their voice be heard in the review?

- How was the race, culture, faith, and ethnicity of the child and/or family considered by practitioners and did cultural consideration impact on practice?
- How did any disability, physical or mental health issues, and any identity issues in the child and/or family impact on the child's lived experience and on practice?
- Were any recognised risk factors present or absent and did they play a significant part in the child's lived experience?
- Can any relevant national reviews be referenced and used to support local learning?
- Are there issues identified that are of national significance? Is a national review considered to be necessary following the rapid review? If so, why?
- Are there sufficient and sound reasons to proceed with an LCSPR? If it is decided to proceed with an LCSPR, an appropriate scope should be specified, with some identified key lines of enquiry.
- Does the review identify relevant good practice, and should this be disseminated across the system?
- Has the review identified clear agency and partnership actions to take forward, especially where there is no LCSPR recommended?

Time constraints may restrict the extent to which some of these areas are explored in significant depth. However, some of the points, such as reference to relevant national reviews, should be standard when considering the need for an LCSPR.

The CSPR Panel's guidance states rapid reviews should not include:

- Internal forms used to refer cases to your review group;
- Lengthy multi-agency chronologies or events going back years – unless there is a clear and stated relevance e.g., children who have been removed from the family in the past would be considered relevant;
- Rapid reviews which are verbatim minutes of meetings – focus on summaries and analyses;
- Embedded documents. All relevant information should be included in the text of the rapid review.

Examples of rapid reviews for serious child safeguarding incidents

This document from the CSPR Panel contains anonymised examples of rapid reviews submitted to the panel between 2019 and 2022.

Its aim is to help safeguarding partners complete rapid reviews of serious safeguarding incidents by providing examples of:

- how to set out the facts of the incident
- immediate actions
- learning for the partnership and practitioners

It is important to remember that the purpose of the rapid review is to gather the facts, consider immediate action and potential for improvements, and decide whether to proceed to an LCSPR. The record of the rapid review is to assist safeguarding partners in meeting those purposes and keep a record of their analysis and decision making. It also assists the CSPR Panel in their advice to and consideration of the outcomes. So, the rapid review report needs to contain enough information to inform the above purposes but not so much that it obscures those purposes.

Where a case involves services delivered across more than one safeguarding partnership, the safeguarding partners should liaise and agree which partnership will take the lead in conducting the rapid review. Normally this would be the safeguarding partnership in the area where the child is usually resident.

Consideration should be given to how any other safeguarding partners might be included in the decision making, including whether a joint LCSPR might be required. **Senior representatives of the three safeguarding partners should sign-off the rapid review.**

Where a rapid review has already identified relevant learning and there does not appear to be any scope for further learning to be gained through an LCSPR, the safeguarding partners should outline how learning already identified will be disseminated and acted on, or how the learning outcomes have been achieved. This should be clearly expressed in the rapid review and an appropriate action plan developed.

Involvement of families

There is no expectation to involve families in the rapid review; to do so is normally neither feasible nor appropriate within the timescales. When making a notification, local authority partners should consider whether and how to inform families of the notification. On concluding the rapid review, consideration should be given as to whether and how any learning/recommendations arising from the rapid review should be shared with the family. This contrasts with the LCSPR process where the expectation is that consideration is given to how families, and, where appropriate, children, can be involved in and contribute to the review.

Rapid review timescales

Safeguarding partners should complete and submit their rapid review to the CSPR Panel within 15 working days of notification by the local authority. The Panel recognise that this is challenging and a demanding timeframe. However, keeping in mind the nature and purpose of the rapid review, it is not unrealistic, and can help prevent drift and delays in learning and improvement.

In order to better meet the 15-day timescale and improve the quality, safeguarding partners may send the CSPR Panel a rapid review which has significant information pending, for example, toxicology results, criminal charges, or a long-term prognosis. In most circumstances, though, a rapid review can still be completed, not least because it is the multi-agency working which is the key focus (i.e., what happened between agencies before the incident). Practice prior to the incident can still be reviewed and supplemented, should new information shed further light on how best agencies can work together in the future.

If there are extenuating reasons why the rapid review cannot be completed within 15 working days, the business manager will notify the Secretariat NationalReviewPanel@education.gov.uk

INITIAL SCOPING, INFORMATION SHARING AND THE SECURING OF RECORDS

All relevant agencies who have (or had) involvement with the subject child or family will be required to contribute to a Rapid Review. An initial scoping of agencies' intervention will, therefore, need to be completed and other relevant information rapidly gathered using the *Initial Scoping and Information Sharing* form.

The purpose of the initial scoping and information sharing is to gather the basic facts about the case, including determining the extent of agency involvement with the child and family. More detailed information will be sought if the Rapid Review concludes the case has the potential to identify national or local learning and a decision is made to recommend a national Child Safeguarding Practice Review, a local Safeguarding Practice Review or an alternative learning review.

The *Initial Scoping and Information Sharing* form will be sent out to all relevant agencies **within 2 working days** of receiving the referral, along with an accompanying letter that briefly outlines the referral and explains the purpose of this initial scoping document (*document 2*).

Agencies should prioritise completion of the form and return it **within 5 working days of** receiving it to the Safeguarding Partners' business manager.

All agencies must secure all records/files in relation to the case, so they are not accessible to agency personnel other than through a nominated representative. Where access to the records is required for ongoing case work this must be agreed and monitored by a relevant manager.

SETTING THE DATE OF THE RAPID REVIEW MEETING

The business manager will convene a Rapid Review Meeting and invite key partners who have operational knowledge to attend.

The date of the Rapid Review Meeting will be set as soon as the *Initial Scoping and Information Sharing* form has been sent out. The Rapid Review Meeting will be scheduled **between 7 and 13 working days** of receiving the referral. This will allow for analysis of the initial information to establish the key events in the child's life and inform the Rapid Review Meeting whilst also allowing enough time to prepare the necessary documents for the Panel.

DOCUMENTATION

The following documents will be shared with all those attending the Rapid Review Meeting:

- Northumberland County Council *Serious Incident Notification* form to the Panel
- Completed *Referral Form* that initiated the process;
- Copies of the completed *Initial Scoping and Information Sharing* templates from relevant agencies
- Where relevant Child Death Review Rapid Response Meeting minutes

Wherever possible the documentation will be shared with participants in advance of the meeting. However, it is recognised that it may on occasion be necessary to share documentation at the meeting.

THE RAPID REVIEW MEETING

The Rapid Review Meeting will:

- Review the facts about the case as presented in the documentation;
- Discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately;
- Consider the potential for identifying improvements to safeguard and promote the welfare of children;
- Decide whether to recommend a National or Local Child Safeguarding Practice Review. If the decision is not to proceed with a formal Child Safeguarding Practice Review, the meeting will also consider whether an alternative form of learning review is appropriate. In some cases, the Rapid Review process may identify key local learning that can be quickly acted upon, removing the need for further review

The *Rapid Review Meeting* record will be completed following meeting and agreed by those who attended meeting (via email).

CHAIRING THE RAPID REVIEW MEETING

The Rapid Review Meeting will be chaired by the chair of the SPRG as and when required.

SHARING THE OUTCOME OF THE RAPID REVIEW

Within 2 working days of the Rapid Review Meeting, the completed *Rapid Review Meeting* record will be sent to the Panel and the attendees, by the business manager, together with a covering letter to the

Panel. Other agencies (including the agency who made the referral) will be informed of the outcome of the Rapid Review.

The recommendation of the Rapid Review Meeting will be shared with the SPRG, so if required they can oversee the commission and progress of the review. Individual agencies should notify their own inspectorate bodies as required.

Rapid Review Process - Summary

Breakdown of the Rapid Review Process and the suggested timescales in order to meet the 15 working days target:

Within 1 working day of Serious Incident Notification

- NCASP buisness manager notifies safeguarding partners and chair of SPRG via email
- Date set for Rapid Review Meeting (business manager)

Within 2 working days of referral

- Initial Scoping and Information Sharing Template sent to all relevant agencies

Within 5 working days

- Completed Initial Scoping and Information Sharing Template returned by agencies and then shared with those attending the Rapid Review meeting along with the Referral Form and LA notification

Between 7 and 13 working days of receiving the referral

- Rapid Review Meeting
- Reviews the facts about the case presented in the documentation
- Agree any immediate action
- Consider the case against the criteria for a Local Safeguarding Practice Review
- Decide whether a practice review or other learning review should take place
- Complete the Rapid Review Template (chair of rapid review) and agree the recommendations (safeguarding partners)

Within 2 days of the Rapid Review meeting

- Rapid Review Template and accompanying letter sent to CSPR Panel (business manager)
- Agencies (including the agency who made the referral) are informed of the outcome of the Rapid Review

Within 5 days of Rapid Review Meeting

- Chair of SPRG informed of the decision of the Rapid Review Meeting, including any proposed model, methodology and timescale for completion

7. Local Child Safeguarding Practice Reviews

Purpose and Criteria for Child Safeguarding Practice Reviews

The purpose of a child safeguarding practice review is to explore how practice can be improved through changes to the system itself. Reviews should seek to understand both why mistakes were made and to comprehend whether mistakes made on one case frequently happen elsewhere and to understand why.[1]

Reviews do not replace the role of regulatory bodies and should not be used to hold individuals to account for not meeting professional standards, however, if potential errors or malpractice is identified, the relevant procedure for addressing this issue should be followed by the agency concerned.

Definition of a Serious Child Safeguarding Case

Working Together 2018 defines serious child safeguarding cases as those in which: abuse or neglect of a child is known or suspected and the child has died or been seriously harmed.

Serious harm includes (but is not limited to) impairment of physical health **and** serious / long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development.[2]

Working Together 2018 advises that consideration be given to whether impairment is likely to be long-term, even if this is not immediately obvious. Even if a child recovers, serious harm may still have occurred.

Child perpetrators may be the subject of a review, if the definition of a serious child safeguarding case is met.

Criteria for a Local Child Safeguarding Practice Review

Safeguarding Partners are required[3] to consider certain criteria and guidance when determining whether to carry out a Local Child Safeguarding Practice Review.

They **must take into account** whether the case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified;
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children;
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children;
- is one which the National Panel have considered and concluded that a local review may be more appropriate.

They should also **have regard to** the following circumstances:

- where the Safeguarding Partners have cause for concern about the actions of a single agency;
- where there has been no agency involvement and this gives the Safeguarding Partners cause for concern;
- where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around;

[1] This definition is taken from the Practice Guidance issued by the National Child Safeguarding Review Panel on 5 April 2019
[2] This is not an exhaustive list
[3] by the Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018

- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.[4]

Deciding whether to conduct an LCSPR

It is for safeguarding partners to determine whether an LCSPR is appropriate, considering that the overall purpose of a review is to identify improvements to local practice and wider systems. Just because an incident meets the criteria for notification in Working Together 2018 does not mean there is an automatic expectation to carry out an LCSPR.

Safeguarding partners need to be clear from the outset what the benefit would be of conducting an LCSPR following on from a quality rapid review. Rapid reviews should always set out a very clear rationale for doing an LCSPR and should be explicit about the key questions that the LCSPR would seek to answer.

Good practice LCSPRs identify new learning that is not yet available in local safeguarding systems, or they tackle perennial problems that need further or perhaps different attention. An LCSPR does not automatically explore learning from a rapid review in more detail although partners may decide to initiate an LCSPR for this reason.

If a child has been notified and the rapid review subsequently identifies that the notification criteria is no longer met (for example, there is no evidence of abuse or neglect, or the harm suffered was deemed not to be serious), the safeguarding partners may nevertheless decide to carry out an LCSPR if they deem that there is still potential for further learning and a clear rationale for doing so.

It is important to remember that the responsibility for decision making rests with the safeguarding partners therefore it is important to document who participated in the rapid review to ensure that the executive leads 'own' the decision. Where that responsibility has been delegated it is important to be clear on the lines of accountability. While the views of the independent scrutineer are valuable, they do not replace the responsibility of the safeguarding partners.

Occasionally the Panel may question the decision to conduct an LCSPR if we do not feel there is sufficient justification or information about need for further review. Similarly, the Panel may question a decision not to conduct an LCSPR if it feels that the rapid review has not adequately explored the learning or if there may be further learning to be gained from an LCSPR. This is explored further under the section *How the Panel Works*.

Approach and Principles

NCASP have agreed that their approach will be 'systems based'. Each case will, however, be examined individually to determine the most appropriate methodology to identify and maximise learning – See Section 11

Decisions on whether to undertake a review will be made transparently and the rationale shared with all relevant partners, including families. **The child will be placed at the centre of the process**.

All reviews will be proportionate to the circumstances of the case and focus on the potential learning. Specifically, all reviews will be conducted in a way which:

- reflects the child's perspective and family context;

[4] This includes children's homes (including secure children's homes) and other settings with residential provision for children; custodial settings where a child is held, including police custody, young offender institutions and secure training centres; and all settings where detention of a child takes place, including under the Mental Health Act 1983 or the Mental Capacity Act 2005

- considers and analyses frontline practice as well as organisational structures and learning;
- establishes the reasons why events occurred as they did;
- identifies clear learning that will improve outcomes for children.

Practitioners will be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

All participants in the review process will be asked to declare any potential conflicts of interest and will be expected to sign, and adhere to, a confidentiality agreement.

Engaging Children and Family Members

Using the information available, and the genogram where available (see section 10), consideration will be given to which family members are relevant to the review and how the family, siblings and the child (where the review does not involve a death) should be invited to contribute (unless there is a strong reason not to) The information and support that children and family members are likely to require to effectively engage will also be identified.

Steps will be taken to sensitively manage their expectations and ensure they understand how they are going to be involved. Plans to engage children and family members will need to take into account any parallel investigations.

Working Together 2018 provides guidance on commissioning a reviewer or reviewers for an LCSPR. The key consideration is whether the reviewer has the appropriate knowledge and expertise of the child safeguarding system to undertake the review.

The reviewer should be able to take a critical and authoritative stance to identifying multi-agency learning. To that end the reviewer should have no real or perceived conflict(s) of interest – i.e. be independent of the case.

NCASP may consider using capacity within local partnership organisations to undertake LCSPRs, as appropriate and provided the person has suitable skills to undertake reviews and is independent of the case (with no real or perceived conflict of interests).

CSPR Guidance:
Sometimes safeguarding partnerships propose undertaking an 'alternative learning review' or use other terminology to describe different approaches to further review.

We support and encourage different methodologies and approaches to review; however, any further review of a case should be referred to as an LCSPR and should meet the requirements of an LCSPR, including the appropriate involvement of practitioners and families and the expectation that the report will be published within 6 months.

Any decision to undertake a further review of the case should be carried out as an LCSPR. This is different to the dissemination of learning arising from a rapid review.

Where a rapid review has identified important learning, such that further review of the case is not needed, then consideration should be given to how that learning is disseminated – for example through practitioner learning events or practice briefings – such approaches do not require further review of the case and should not be referred to as reviews.

Good practice guidance for carrying out LSCPRs

- The scope, aims, and terms of reference of the LCSPR should be determined at the start and should be specified clearly in the final report. They should stem from the learning identified in the rapid review.

- While undertaking an LCSPR, alternative lines of enquiry or methods might be required and any amendments should be reflected in the final report.

The best LCSPRs start with the key lines of enquiry, questions a review is seeking to answer, and provide evidence and analysis of what the scope and focus of the review will be.

- Key lines of enquiry should be few in number (no more than 3 or 4 key questions) and focused on the most important issues for learning. This should be accompanied by a concise summary of the circumstances and background of the case in order to lend appropriate context to the reflection and learning of the LCSPR that will follow.

- As stipulated in Working Together 2018, all reviews should reflect the child's perspective and the family context. This does not require a descriptive account of all events; the aim is to provide appropriate and meaningful context, sufficient to illuminate the major theme or themes arising from the case.

- Key practice episodes can be used to analyse significant events in the chronology and to focus on the role of agencies at these times. Key lines of enquiry can also help to determine questions for agencies and families and can help structure conversations, so the valuable insight is extracted. Structure and prompts can help get to the core of the practice issues, but conversations should also allow for unstructured contributions and reflection.

- The lived experience of a child and where possible and appropriate, their voice, should be dominant throughout a review. LCSPRs should specifically consider these aspects in their analysis of the circumstances of the case, their appraisal of practice, and in the methods applied to the review.

- It is imperative that an LCSPR considers the characteristics of a child's identity – such as race, ethnicity, gender, disability. It is important than an LCSPR discusses if and to what extent the characteristics and cultural background of a child and/or family may have impacted professional decision making.

- Racial, ethnic, and cultural issues are pivotal factors and should be given proper weight when exploring the reality of children's lives in LCSPRs.

Since its inception, the CSPR Panel has considered a number of LSCPRs that did not give due consideration of the child's personal characteristics, for example their race, sexual orientation, gender, ethnicity or disability.

- A request to agencies for information about the case, policy or procedure can be made to enhance understanding or a particular episode. This can be a useful mechanism for securing formally and quickly further information.

- An LCSPR should not necessarily be limited to reviewing the specifics of one family and a specific incident but rather be used to also explore broader aspects of practice, to ascertain whether there are systemic practice issues to be addressed. Study of the particular incident creates the opportunity to study the whole system, both what is working well and what is not, looking at the underlying issues that are influencing practice more generally.

CSPR Panel:
Too many LCSPRs are written in the style and approach of 'old style' Serious Case Reviews (SCRs); they often have overly long chronologies, use SCR methodologies and approaches that do not engage in sufficient depth with system problems, nor do they explore why issues and practice problems may have occurred and what therefore needs to change as a result.

This approach often leads to unacceptable delays in completion and publication along with bland and ineffective recommendations. We encourage creative thinking around how best to approach reviewing each case in light of the identified key lines of enquiry/ review questions.

- An LCSPR can benefit from bringing in wider relevant evidence related to the case. For example: the context of the local area, data and analysis relating to agencies and services, national or international evidence and learning from other LCSPRs and/or national reviews.

- Where there are large numbers of professionals involved in an incident from a range of agencies their involvement should be carefully summarised and focus on key practice episodes to avoid overly long LCSPR chronologies.

- Human error, where it is identified, should be a starting point for exploring any deeper systemic issues, and not the conclusion of the review. Asking, *why did the person act in the way they did* and *what was the environment and context in which they were operating*, while avoiding an over-focus on what happened is more likely to lead to effective learning and recommendations. This does not in any way detract from the importance of those in positions of authority, particularly senior leaders, and managers, taking responsibility for the systems and structures and how those are worked out, nor of all professionals taking responsibility for their own actions.

Legal Advice

In each case, it is to be decided whether legal advice is required at the outset and whether this is available. Legal advice can also be sought during the review or prior to publication.

Timescale for Completion of the Review

Reviews will vary in their breadth and complexity but in all cases learning should be identified and acted upon as quickly as possible. This includes before the review has formally commenced and while it is in progress.

All statutory Local Child Safeguarding Practice Reviews should be completed no later than ***six months*** from the date of the decision to initiate a review. Reviews should be proportionate and it should, therefore, be possible to complete less complex cases more quickly.

Sometimes the complexity of a case does not become apparent until the review is in progress. For example, the police undertaking a criminal investigation may in some instances request the review delay involving specific key individuals. Any delays need to be considered by the Safeguarding Practice Review Group/ Safeguarding Partners as soon as they arise. If the delay will prevent the publication of the final report within six months, the CSPR Panel and Secretary of State should be informed and provided with the reason for the delay.

Strategic Leadership and Governance

The CSPR Panel does not have the power to require local Safeguarding Partners to undertake reviews. Ultimately, the decision to proceed to a Local Child Safeguarding Practice Review is always a local decision

for which local Safeguarding Partners are accountable. This includes the identification of cases, commissioning and supervising of reviews, and the publication of reports and embedding learning.

NCASP will convene a Safeguarding Practice Review Group when a serious incident is referred to them. This Group will undertake a rapid review of each serious incident referred to them and will take responsibility for commissioning and overseeing any Local Child Safeguarding Practice Reviews. This will include monitoring case progression, quality assurance and publication of final reports, and ensuring effective oversight of the implementation of learning.

All decisions related to the commissioning and publication of Local Child Safeguarding Practice Reviews will be notified to the CSPR Panel, the Department for Education and Ofsted.

If the National Panel disagree with the decision of the Rapid Review or publication of the report, it may be necessary to put forward a challenge. This is relevant if more information becomes available to support the original decision.

The final step in the approval and quality assurance of the completed report will be by way of presentation of the report, a summary of the main findings and learning to the Safeguarding partners.

Interface with criminal investigations and proceedings:

- The LCSPR process can often run in tandem with ongoing criminal proceedings and as such safeguarding partners sometimes take the decision to delay the LCSPR process until the conclusion of the criminal proceedings which may be several years after the serious harm or death of a child has occurred. **However, the existence of criminal proceedings should not automatically lead to a decision to delay the LCSPR process.**

- The criminal process and LCSPR process consider fundamentally different things. An LCSPR looks at system learning, and the criminal process is looking at individual culpability. The timeframe under consideration is also often different, as the LCSPR will be focused on multi-agency activity/inactivity before the death or serious harm. Whereas the criminal process will be focussed on what happened at the time of the death or serious harm. Therefore, when considering whether or not to delay the LCSPR process, safeguarding partners should give careful consideration to the proposed key lines of enquiry.

- Where the learning is restricted to systemic weaknesses in multi-agency practice, then the LCSPR process and the implementation of learning should not be delayed.

- Where there are potential overlaps in relevant timelines under consideration in the criminal and LCSPR processes it may still be possible conduct the LCSPR (with clear agreed key lines of enquiry) and implement the learning but delay the publication of the LCSPR.

- The Crown Prosecution Service has issued guidance about how any risks to criminal proceedings can best be managed and mitigated. https://www.cps.gov.uk/publication/protocol-liaison-and-information-exchange-when-criminal-proceedings-coincide-child & Major-Crime-Investigation-Manual-Nov2021.pdf (college.police.uk)

- Where there are concurrent criminal investigations, there may need to be negotiations around the scope and the methods used in the review. Negotiation with police and/or CPS at the outset about what the safeguarding partnership intends to review and how it will be undertaken will, in most cases, allow the LCSPR to complete without interfering with a criminal investigation or prosecution.

- In criminal proceedings the availability of witnesses is a commonly stated problem, but this should not prevent LCSPR work being undertaken, with any gaps in learning from not undertaking particular interviews being addressed later. Often safeguarding partnerships wait many months, if not years, to speak to families or extended families only to be told that they do not wish to engage. Therefore, the review focus should be on prompt learning embedded into system and practice improvement.

- Concerns about compromising witness statements can be avoided in rapid reviews and LCSPRs by using methodologies that enable reflection, analysis and system learning that do not focus on individual practitioner action or inaction but helps create the conditions for improved practice relevant to the context of the case.

Where safeguarding partners are concerned about the timeline for publishing an LCSPR prior to the conclusion of criminal proceedings, CSPR panel suggest contacting their Secretariat who can facilitate dialogue with Panel.

The interface with other statutory processes and parallel investigations:

- A serious incident may trigger more than one statutory review process. It remains important for safeguarding partners to organise locally how these can successfully combine while still meeting the core purpose of each.

- The case may also be subject to a criminal or coroner's investigation, individual agency or professional body disciplinary procedures. It is anticipated that a Local Child Safeguarding Practice Review will go ahead unless there are clear reasons not to.

- Under Working Together 2018 there is discretion as to when a local child safeguarding practice review should take place and who does it. This will create greater flexibility in designing a single review mechanism, which still meets a variety of specific statutory obligations.

- Where there are parallel investigations, this is best considered at the scoping stage to reduce duplication and the impact on children and families and to maximise learning.

- It is possible for partners to work together to deliver on a report that cover the necessary requirements of, for example, a Domestic Homicide Review or Safeguarding Adult Review as well as a child safeguarding review.

- This will be appropriate where separate review processes arise from a single or linked incident, for example children are living in an abusive and neglectful home and their mother is killed by their father.

- When undertaking a joint report it is important to ensure that the key requirements of both processes are clearly identified and met.

Local Child Safeguarding Practice Review – Summary

- An agency identifies a case which will benefit from a Child Safeguarding Practice Review as it raises issues of importance for the local area (good practice/poor practice or where there has been a "near miss" event or in other circumstances).

- This should be discussed with the safeguarding partners' representatives or a senior manager within their organisation who then discusses the case with a safeguarding partner representative.

- A request to consider a Child Safeguarding Practice Review can be made. The request should be made via the Secretariat using the Request to safeguarding partners for a case to be considered a local Child Safeguarding Practice Review form.

- The Secretariat will inform the safeguarding partners that a request has been made. Three partners will consider whether a Serious Incident Notification should be made or not.

- Once the initial decision is made to notify the incident as serious, the safeguarding partners' representatives (core members of the SPRG) discuss the case and make a recommendation on whether to complete a Child Safeguarding Practice Review or not. The safeguarding partners will agree a response/decision.

- The SPRG will agree the methodology, scope and terms of reference for the review which will include how an independent author will be appointed or how independent contributions will be made from across the local network.

- The methodology chosen will capture the views of service leaders, frontline practitioners and the family and focus on identifying areas that need further exploration. This will be endorsed by the safeguarding partners.

- The SPRG will review the progress and quality of the local CSPR at the relevant intervals requesting information in writing from the reviewer.
- The SPRG will also capture ongoing learning about improvements needed and take corrective action.
- The safeguarding partners will be updated on the progress and agree to any learning being disseminated during the CSPR.

The final report will be published and will include:

- Issues relating to race, ethnicity, religion, gender, sexuality, disability and poverty with an analysis of the impact of these on children and families that will form important contextual background to their circumstances and to the incident being reviewed.
- A summary of any recommendations improvements to be made in the area to promote the welfare of children.
- An analysis of any systemic or underlying reason why actions were taken or not taken in respect of matters covered by the report.

The final report will be endorsed by the safeguarding partners.

The final signed off report is published on the NCASP website upon agreement by the safeguarding partners and sent to the National Panel and Ofsted.

- The SPRG will devise an action plan in response to the recommendations within the final report.
- The action plan will be regularly reviewed, and the implementation of recommended improvements overseen by the CSPR.
- The SPRG will also communicate the findings and identified improvements to relevant parties.

The Action Plan will be finally signed off by the safeguarding partners at the NCASP Executive.

The Safeguarding Partners may decide to request that an independent scrutiny officer complete an audit/assurance event to ensure improvements are embedded into multi-agency practice.

8. Information Sharing

Information sharing is essential to safeguard and promote the welfare of children and young people. Effective Child Safeguarding Practice Reviews are equally dependent on all relevant partners sharing the information they hold about the case and associated professional practice.

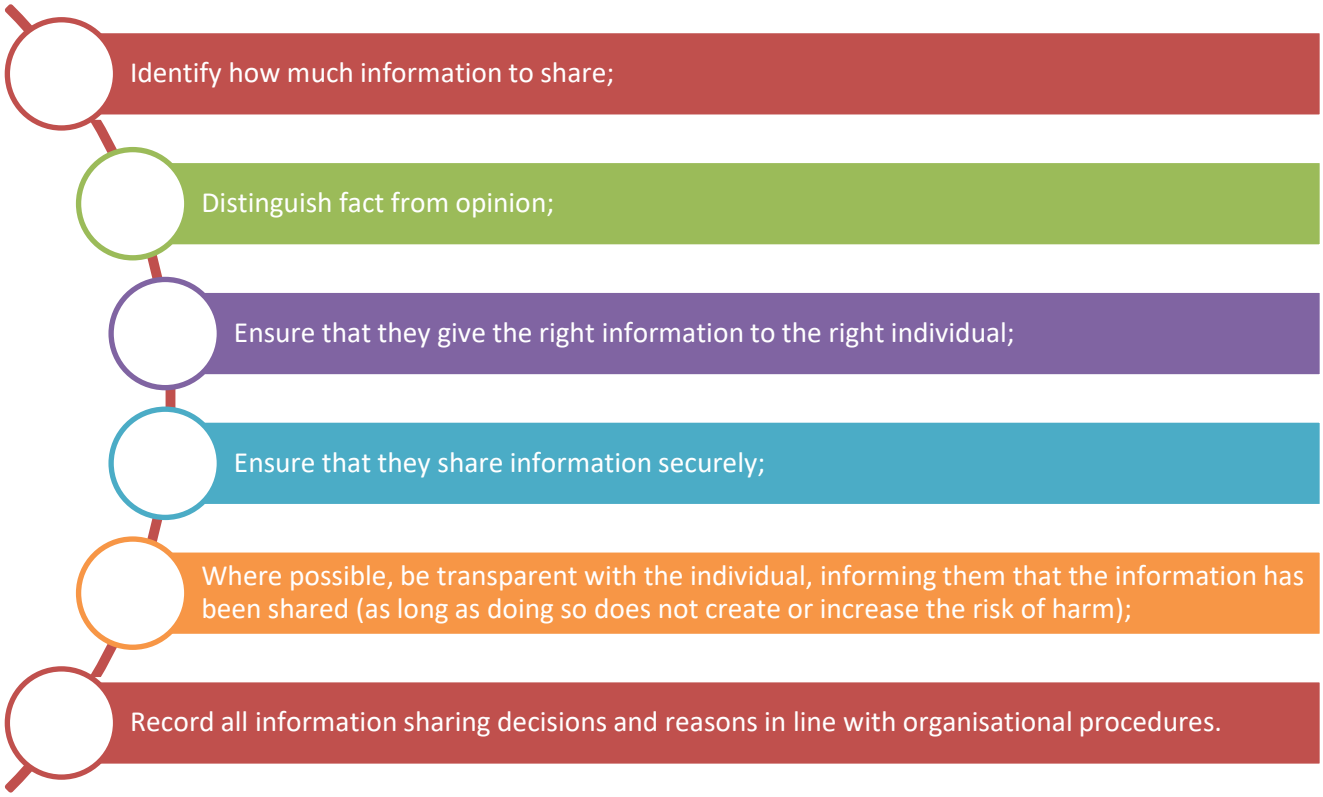
The Safeguarding Partners have the formal authority to request information to support both national and local Child Safeguarding Practice Reviews and the power to take legal action if information is withheld without good reason.

All agencies will be expected to share relevant information within the timescales requested. This may, when necessary, include sharing information without consent (such as where there is an ongoing police investigation). This includes information about parents, guardians, and other family members as well as the child(ren) who are subject of the review.

Where a request is for health records this applies to all records of NHS commissioned care whether provided under the NHS or in the independent or voluntary sector.

When making requests for information, the Safeguarding Partners will consider their responsibilities under the relevant information law and have regard to guidance provided by the Information Commissioner's Office.

Good practice principles around information sharing will always be followed, particularly around 'how' information is shared. For example, when responding to requests for information, agencies should:



In the case of any disagreement or failure to comply with a formal information request, the Independent Lead Reviewer or a Review Team member will refer the issue to the Safeguarding Practice Review Group who will seek to resolve this with the strategic Safeguarding Lead for the agency concerned. If a prompt resolution cannot be found, the issue will be escalated to the Safeguarding Partners for formal action.

9. Appointing the Lead Reviewer and Review Team

The Lead Reviewer

A Lead Reviewer will usually be appointed to manage the review process, chair meetings of the Review Team, facilitate the Learning Workshops and author the final report. However, a Lead Reviewer may not be required where shorter 'proportionate' reviews are conducted.

The Safeguarding Partners will inform the National Panel, Ofsted and the Department for Education of the name of any reviewer commissioned via email to:

- Mailbox.NationalReviewPanel@education.gov.uk
- SCR.SIN@ofsted.gov.uk
- Mailbox.CPOD@education.gov.uk

The Review Team

For complex reviews, a small, multi-agency Review Team will usually be established to assist the review process. This will include a representative from each of the Safeguarding Partners along with any relevant subject matter experts depending on the case.

The Review Team will support the Lead Reviewer to scrutinise the information provided by agencies. The Review Team will also provide local context and challenge to the analysis of professional practice and the identification of learning. Where a report is not of the quality expected then the Lead Reviewer will make contact with the relevant agency and ask for the report to be revised and resubmitted in a timely manner.

The police representative will be responsible for liaising with the Senior Investigating Officer, Crown Prosecution Service, and for co-ordination of family liaison.

10. Engaging Children and Family Members

Approach and Principles

Working Together 2018 highlights the crucial importance of inviting families, including surviving children, to contribute to reviews. This will help ensure that the review reflects the child's perspective and the family context.

In line with good practice consideration will be given to how family members can be supported to engage. This may include interpretation and translation support if English is not a first language, additional support for disabled parents, specialist support where there are issues of domestic abuse, and drawing on expertise to facilitate the appropriate involvement of children.

Family engagement will be included as a standing item at all Review Team meetings. The Review Team will also identify an individual who will take responsibility for co-ordinating communication with family members.

Identifying the Family Network

The lead agency working with the child/family will usually be asked to prepare a full and accurate genogram to assist the clarification of family relationships and dynamics. This will be shared with other agencies at Review Team meetings and in the Reflective Learning Workshop (see Section 9) and will be updated based on any additional information on the family provided by these agencies. The genogram will not be included in the final published report.

Making Initial Contact with the Family

Family members, including surviving children, will be informed of the review and invited to contribute unless there is a strong reason not to do so. The initial planning meeting (described under Section 6) will discuss family involvement and agree an approach that will sensitively manage their expectations and ensure they understand the process.

Personal contact should be made whenever possible by the most appropriate professional and the family provided with a letter and/or leaflet to explain and introduce the review process and Lead Reviewer. See Sample Letter to Family Members (Document 8) and Sample Leaflet on Child Safeguarding Practice Reviews (Document 9).

Conversations with Family Members

Family engagement will normally be led by the Lead Reviewer and conversations should ideally take place before the Learning Event (described in Section 9) so that the family's views can be included alongside the analysis of professional practice. Where a Lead Reviewer is not commissioned, the local area will nominate the organisations / individuals responsible for liaising with the family. However, engagement may not be possible until the outcome of any criminal proceedings.

It is recognised that family members may decide not to take part in the review. All reasons for non-involvement of family members (for example, parallel investigations or the choice of the individual) will be documented in the final report.

11. Methodology

The 'Systems Methodology' and Expectations of Agencies

Working Together 2018 does not specify the methodology that should be used in Local Child Safeguarding Practice Reviews but there is an explicit expectation that 'principles of the systems methodology recommended by the Munro Report' will be 'taken into account' by the Safeguarding Partners when agreeing the method by which the review will be conducted.

This section describes one systems-based approach that may be adopted for Local Child Safeguarding Practice Reviews in Northumberland. This is consistent with both the guidance in Working Together 2018 and the principles of the systems methodology recommended by the Munro Report.[5]

Each case will, however, be examined individually and the methodology will be adapted to meet the specific needs of the case, to ensure a proportionate response, and to maximise learning to improve both frontline safeguarding practice and organisational structures. The Safeguarding Partners may agree to use a different methodology.

Agency Action and Expectations

All agencies which provided services to the family during the time period specified in the Terms of Reference will be formally requested to participate in the review process. The extent of agency engagement will be dependent on the type of review commissioned, the specific Terms of Reference, and the methodology chosen.

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[5] The systems approach described in this guidance was developed based on the model described in SCIE Guide 24: *'Learning together to safeguard children: developing a multi-agency systems approach for case reviews'* by Dr Shelia Fish, Dr Eileen Munro and Sue Bairstow (January 2009) and following research into best practice around Serious Case Reviews. It incorporates elements from a number of areas but has a particular debt to the model described by Essex Safeguarding Children Board

Each organisation should have an identified Safeguarding Lead to act as a single point of contact for the co-ordination and support of the review process.

Agencies should ensure that all requests for information are acted upon in a timely fashion and practitioners are released to participate in the review. Agencies should also provide support to their staff who are affected by the case where required.

Information Collection and Collation

Where required, information will be collected through the use of Chronologies and/or Information Reports. The Terms of Reference will specify the information collection and collation tools that will be used in the review.

Chronologies

Where chronologies are used, all relevant agencies will be asked to complete a Chronology of their agency's involvement. They may also be asked to produce a chronology of any organisational changes which may have impacted on frontline practice during the same period.

Chronologies and any other Information Reports should avoid referencing the names of any individual practitioner but make clear the role and areas of responsibility of the individual in the case under review.

An example Chronology Template (Document 10) and Accompanying Letter (Document 11) are provided in the supporting documents, along with Guidance Notes on Completing the Chronology (Document 12).

Review Team Quality Assurance of Agency Submissions

The work of the Review Team, chaired by the Lead Reviewer, begins once initial information has been gathered. The Review Team needs to be satisfied that the appropriate level of information has been provided by each agency and that the analysis provides sufficient insight into the actions undertaken by the agency and possible learning.

If necessary, the Review Team may decide to either request more information from an individual agency or invite them to attend a meeting if further clarity is needed about their agency's role with the child and/or family.

Establishing Key Themes

The Review Team will discuss the case in detail and confirm and agree the Key Themes for Analysis building on learning from the Rapid Review and any lines of enquiry that may have been developed as part of the Terms of Reference. These themes should be as few as practicable and focus on core learning.

The key themes should identify issues of practice that have emerged within the case which can (i) be transposed into working with families more generally and (ii) give insight into the systems which operate formally or informally within safeguarding practice. Some examples might be "making space and time for children" or "the use of assessments to inform future interventions".

The Key Themes for Analysis may be shared with participants prior to their attendance at the Reflective Learning Workshop.

Reflective Learning Workshop

Reflective Learning Workshops provide a forum for frontline professionals and their line managers to come together in a respectful, positive and supportive environment to consider the circumstances surrounding the case and the reasons why actions were taken. This enables the Lead Reviewer and Review Team to identify important multi-agency learning.

Preparing for the Learning Workshop

The Review Team will need to ensure it has a full list of appropriate professionals to invite to the Learning Workshop. This will usually be requested alongside the Chronology and/or Information Report.

To maximise learning all agencies are expected to ensure that appropriate staff attend the workshop. However, it is preferable that only those who have had some form of direct operational involvement with the child and family attend.

Invitations to Reflective Learning Workshop (Document 13) will be sent to all participants giving plenty of notice. This will be accompanied by a short briefing document which explains the purpose of the event and the importance of attending (Document 14).

The Structure of the Learning Workshop

Reflective Learning Workshops may be held 'face to face' or virtually.

Where a 'face to face' meeting is held, the Reflective Learning Workshop will normally be undertaken over half a day, although a more complex case may require an additional half day. See the Sample Agenda for a Reflective Learning Workshop (Document 15).

Reflective Learning Workshops may also be held virtually using meeting software such as Microsoft Teams. These will usually be held over a 3 hour period with a break at an appropriate time. Where a large number of professionals have been involved in the case, a series of smaller online workshops may be organised to ensure all participants are able to engage.

The use of 'worksheets' can be beneficial helping participants to focus on learning, undertake preparation, capture key points during the event, and provide post-event feedback. See Example Worksheets for a Reflective Learning Workshop (Document 15a).

The Lead Reviewer will normally facilitate the Reflective Learning Workshop, supported by members of the Review Team.

The structure of the Workshop will vary depending on the case but is likely to include a discussion of:

- the information compiled about the family in terms of incidents and professional interventions with an opportunity for participants to query the factual accuracy, to add information and to agree changes;
- the "lived experience of the child/children". This enables participants to view what happened from the child's perspective;[6]
- the reasons why events and practice happened the way they did, including any organisational and 'systems' factors that may have shaped behaviour (such as organisational/team aims or culture, levels of supervision, or the resources available to deliver services);
- the key themes which have emerged in the case and whether they can be transposed to working with families more generally;
- any examples of good practice;
- the learning from the case and actions that should be taken to better safeguard children in the future.

Within these discussions it is essential that all actions and decisions (or lack of them) by professionals are viewed within the context of the information available at the time and system in which they were working.

[6] As outlined under section 8, this is an important requirement of Working Together 2018 as well as good practice in child safeguarding practice reviews

The Lead Reviewer will assist the group to avoid hindsight bias in their consideration of what took place.

Conversations with Key Practitioners

Where an individual with important information to contribute to the review is unable to participate in a Reflective Learning Workshop, arrangements may be made to facilitate a conversation with the Lead Reviewer to enable them to contribute to the learning.

Depending on the methodology used, the Lead Reviewer may wish to meet with individual practitioners prior to the Reflective Learning Workshop.

12. The Report

The LCSPR should have clear recommendations that address both practice and system leadership issues.

- The LCSPR and accompanying action plan need to be owned and signed off by the three safeguarding partners.
- The expectation is that unless there are compelling exceptional circumstances, all CSPRs will be published.
- LCSPRs should be written in such a way so that what is published avoids harming the welfare of any children or vulnerable adults involved in the case.
- There is an expectation that all reviews will be completed and published within six months, circumstances such as ongoing criminal or other investigations are not, of themselves, a reason to delay completion, and any likely delays beyond six months should be discussed with the Panel.

Changes to practice emanating from LCSPRs need to be led by safeguarding partner leaders. Systems need to be put in place locally so that there is assurance that practitioners have adopted the required changes in practice.

Reports should meet any requirements specified in the agreed Terms of Reference for the review and, as a minimum, should also succinctly include:

- a brief overview of what happened and the key circumstances, background and context of the case. This should be concise but sufficient to understand the context for the learning and recommendations;
- a summary of why relevant decisions by professionals were taken;
- a critique of how agencies worked together and any shortcomings in this;
- whether any shortcomings identified are features of practice in general;
- what would need to be done differently to prevent harm occurring to a child in similar circumstances;
- examples of good practice; and,
- what needs to happen to ensure that agencies learn from this case.

The Review Team will be responsible for ensuring the draft report has met the agreed terms of reference, is succinct and focused on improving local safeguarding arrangements.

Reports should not contain substantial or unnecessary personal biographical details relating to children and families which would compromise publication. Any personal Information should be appropriately anonymised and very intimate and personal detail of the family's life should be kept to a minimum to reduce the sensitivity of publication.

The Review Panel will be responsible for ensuring the draft report has met the agreed terms of reference, is succinct and focused on improving local safeguarding arrangements. *(A Guidance on Drafting a Report can be found in Document 16)*.

The final report should be formally approved by the statutory Safeguarding Partners

The CSPR Panel has developed some framework questions which the Panel use to consider whether an LCSPR is of good quality:

1. •Is there a clear rationale for the scope of the LCSPR based on the analysis from the rapid review?
   •Is the review focused?
   •What are the key lines of enquiry that the review is seeking to address?
2. •Has the chosen methodology helped with exploring the identified themes?
3. •Where relevant to the focus of the review, does it give a sense of the daily life of the child/children?
4. •Where relevant to the focus of the review, does the report consider the race/ethnicity and any disability of the child/children?
   •Does it interrogate potential direct or indirect experiences of discrimination?
5. •Where relevant to the focus of the review, does the report explore intersectional identities of the child/children?
6. •Where relevant to the focus of the review, does the report show an understanding of the distinct context for the child/children (background, culture and history)?
7. •What is the quality of analysis and interpretation of findings?
   •Does the review go beyond simply identifying 'what went wrong' to consider the impact of organisational context and leadership, and any system issues underlying practice?
8. •What is the quality of identified learning points, recommendations, and any linked action plans?
9. •Is the report timely and with a quality structure (including independence of author, accessibility, usefulness, length etc)?
10. •Are there implications for local/national practice and/or policy?

Developing the Recommendations

The analysis of the information collected during the review coupled with the feedback from the Reflective Learning Workshop should lead to the identification of key learning.

This learning will be developed into formal recommendations that will form part of the final report. In most cases, the Lead Reviewer and Review Panel will develop draft recommendations. The SPRG will consider the learning and further develop meaningful recommendations so that key strategic stakeholders will be engaged and consider the potential learning in the context of wider operational and strategic developments: this will ensure that recommendations are focused on the issues that will make a real difference and, therefore, maximise the opportunity to deliver meaningful change.

In all cases, recommendations will be focused on improving outcomes for children and should be clear about what is required of relevant agencies and others collectively and individually, and by when.

The formal recommendations will be endorsed by the statutory Safeguarding Partners before being included in the report.

13. Feedback to Family

Where possible, the final draft report should be shared with the relevant family members in order to advise them of the main findings, recommendations and plans for publication. The family will have an opportunity to comment on the report and amend any factual inaccuracies that relate to personal details.

The wishes of the child's family will be considered as part of the publication and media planning (see section 21). The proposed publication arrangements will then be discussed with the family and appropriate steps will be taken to minimise the disruption and distress that any media attention surrounding the publication may cause to family and friends.

14. Practitioner and Managers Feedback

Practitioners who have participated in the review will often be invited to provide feedback towards the end of the review process. The Lead Reviewer / Review Team will share the learning that has been identified and provide practitioners with an opportunity to comment on the accuracy of the analysis before the review report is finalised.

Practitioners may also be invited to consider how learning can be transposed into practice on a day to day basis and practical issues around the implementation of possible improvements.

15. Publication and Communications Strategy

The Safeguarding Partners are required to publish the reports of Local Child Safeguarding Practice Reviews, unless they (in collaboration with the Child Practice Review Group) consider it inappropriate to do so.[7]

Preparing for Publication

Publication and media planning is undertaken in conjunction with the Local Authority Communications Team who will liaise with the relevant Communications / Media Leads of the organisations involved *(see*

[7] If they consider it inappropriate to publish the report, they must publish any information about the improvements that could be made following the review.

example Communications strategy Document 17). Publication and media planning will commence prior to formal endorsement of the report by the Safeguarding Children Partnership to avoid delay on completion of the LCSPR.

Managing the Impact of Publication

Consideration will be given to how best to manage the impact of the publication on children, family members, practitioners and others closely affected by the case and to avoid any key dates, for example, birthday, date of incident etc.

The wishes of the child's family will be considered as part of the publication and media planning. The proposed publication arrangements will then be discussed with the family and appropriate steps will be taken to minimise the disruption and distress that any media attention surrounding the publication may cause to family and friends.

The arrangements for informing practitioners will also be considered. It is likely that the senior managers from each agency will take responsibility for informing frontline staff of the date of publication and ensuring they have appropriate support.

Media Strategy

A central point of contact for media enquiries will be a designated person within the Local Authority Communications Team. This individual can co-ordinate media enquiries during the publication phase and ensure effective liaison is maintained with each organisation's strategic and press leads.

Formal Publication

The Safeguarding Partners must send a copy of the full report to the National Panel, Ofsted and to the Secretary of State no later than seven working days before the date of publication. Reports should be submitted electronically to:

- Mailbox.NationalReviewPanel@education.gov.uk
- SCR.SIN@ofsted.gov.uk
- Mailbox.CPOD@education.gov.uk

Published reports will always include the name of the reviewer(s) and will be made available to read and download from the NCASP website.

Reports will be publically available for at least one year and archived reports will be available on request from the Safeguarding Partners.

Published reports will also be submitted for inclusion in the NSPCC National Repository of safeguarding case reviews. Reports will be submitted by email to: information@nspcc.org.uk

16. Embedding Learning

The purpose of a Local Child Safeguarding Practice Review is to identify improvements that can be made to safeguard and promote the welfare of children. Disseminating and embedding the learning is, therefore, crucial.

Capturing Improvements and Taking Corrective Action while the Review is in Progress

The Review Team will consider at every meeting whether any immediate single or multi-agency action is required to respond to emerging issues identified through the review process[8]. They may wish to deliver swift messages to the workforce in specific agencies or disseminate multi-agency learning to a wider workforce. In so doing, the Review Team will consider what information is shared and whether this will have an impact on family members or any parallel investigations.

Disseminating and Sharing Learning from the Review

The relevant Child Safeguarding Practice Review Group, or equivalent, will be responsible for ensuring the identified improvements are implemented locally, including the way in which organisations and agencies work together.

A clear plan for disseminating and sharing the learning from the review with all relevant agencies will be developed. This may include organising single or multi- agency meetings/workshops, or producing briefing notes on the lessons learned for use in agency team meetings and/or supervision sessions.

It is the responsibility of the agencies who have participated in the review to ensure their agency recommendations are fully implemented and used to make improvements to their safeguarding children arrangements.

Monitoring Progress

NCASP will regularly audit progress on the implementation of recommended improvements and will regularly monitor and follow up actions to ensure improvement is sustained. A Sample Action Plan Template (Document 18) is included in the supporting documents.

Taking into Account Learning from National Reviews

The SPRG will periodically consider local trends in the number of and reasons for serious incident notifications, rapid reviews or full reviews, the subsequent learning and recommendations, in order to identify recurring themes, any local safeguarding processes and practices that may warrant further scrutiny and action.
The SPRG will also review the learning from all national reviews and consider how it can be applied at a local level.

17. Appendices and Supporting Documents

Appendix 1: Overview of Different Types of Learning Reviews

Supporting Documents

Deciding whether to commission a Child Safeguarding Practice Review
Document 1: Referral Form
Document 2: Initial Scoping and Information Sharing Template
Document 3: Template Letter – Request for Initial Scoping Information
Document 4: Rapid Review Decision Template
Document 5: Template Letter – Submitting the Rapid Review Template to the National Panel

[8] This ensures compliance with Working Together 2018 which requires that 'every effort should be made, both before the review and while it is in progress to (i) capture points from the case about improvements needed, and (ii) take correction action and disseminate learning.'

Agreeing the Scope and Terms of Reference
Document 6: Terms of Reference Template

CSPR Author Requirements
Document 7: CSPR Author Requirements

Engaging Children and Family Members
Document 8: Template Letter – Informing Family Members of a Review
Document 9: Sample Leaflet – Local Child Safeguarding Practice Reviews

Methodology
Document 10: Sample Chronology Templates
Document 11: Template Letter – Request to complete a Chronology
Document 12: Guidance on Completing the Chronologies
Document 13: Template Letter – Invitation to Reflective Learning Workshop
Document 14: Briefing Note on the role and purpose of Reflective Learning Workshops (to be sent as an appendix to Document 13)
Document 15: Sample Agenda for a Reflective Learning Workshop
Document 15a: Example Worksheets for a Reflective Learning Workshop

The Report
Document 16: Guidance on Drafting the Report

Publication and Communications Strategy
Document 17: Sample Publication and Communication Strategy

Embedding Learning
Document 18: Sample Action Plan Template

Appendix 1 - Overview of Different Types of Learning Reviews

Effective local liaison is required between Multi-Agency Child Safeguarding Arrangements, Adult Safeguarding Boards, Community Safety Partnerships and Multi-Agency Public Protection Arrangements to determine the most appropriate review process to maximise learning and minimise duplication of effort and reduce anxiety for families involved.

Summarised below is a brief outline of the main types of statutory reviews:

Domestic Homicide Review

- Domestic Homicide Reviews (DHR) are commissioned by Community Safety Partnerships and overseen by the Home Office.
- A DHR is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.

Safeguarding Adult Review

- The purpose of a Safeguarding Adult Review (SAR) is to identify lessons to be learned from the case and for the lessons to be applied to safeguard adults more effectively in the future.
- Where a serious case may meet the criteria for a SAR or Local Child Safeguarding Practice Review, liaison will take place between the Adult and Children safeguarding arrangements to discuss primacy and agree the way forward.
- The majority of these cases are likely to focus on transition to adulthood and the potential to improve inter-agency working.

Multi-Agency Public Protection Arrangements – Serious Case Review

- The purpose of the Multi-Agency Public Protection Arrangements (MAPPA) is to oversee the management of violent and sexual offenders.
- MAPPA SCRs examine the effectiveness of partnership working in managing the risk and preventing further offending in the community.
- The aims of the MAPPA SCR will be to establish whether there are lessons to be learned, to identify them clearly, to decide how they will be acted upon, and, as a result, to inform the future development of MAPPA policies and procedures in order to protect the public better. It may also identify areas of good practice

Child Death Review Arrangements

- A child death review must be carried out whenever a child dies, regardless of the cause of death.
- It is the responsibility of the local authority and clinical commissioning group (the 'child death review partners') to ensure the review takes place and to make arrangements for the analysis of information from all deaths reviewed.
- The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified.
- If child death review partners find action should be taken by a person or organisation, they are required to inform them.