Framework and Practice Guidance

Local Child Safeguarding Practice Reviews

Including Serious Incident Notifications and Rapid Review

GATESHEAD safeguarding children partnership

V2 – April 2021

Contents

Who is the Guidance for?

This practice guidance should be read by Safeguarding Partners, and all agencies involved in the Multi-Agency Safeguarding Arrangements.

The guidance is aimed at those involved in undertaking or contributing to Local Child Safeguarding Practice Reviews, such as Independent Lead Reviewers, Review Team 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.

About this Guidance

This guidance provides GSCP with a framework for the commissioning and dissemination of learning from Local Child Safeguarding Practice Reviews. It should be read alongside the relevant statutory guidance set out in Working Together to Safeguard Children (2018).

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

1. Introduction and Context

Introduction

The Children and Social Work Act 2017 introduced a new legal framework in respect of local safeguarding arrangements for children. Responsibility for how a system learns lessons from serious child safeguarding incidents now 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 (clinical commissioning groups, police and local authorities). Local areas no longer conduct Serious Case Reviews. Instead, they need to consider whether to conduct a Local Child Safeguarding Practice Review in cases where abuse or neglect of a child is known or suspected and the child has died or been seriously harmed.

This guidance outlines a shared process for commissioning and undertaking Local Child Safeguarding Practice Reviews in Gateshead. This makes real the commitment to being an improving and learning system, determined to make best use of scarce and precious resources (human and financial) in the best interests of children and families.

This guidance provides professionals with a guide to follow when undertaking or participating in a Local Child Safeguarding Practice Review. It describes the approach, order of events and related timescales whilst also highlighting the key statutory elements outlined in Working Together to Safeguard Children 2018. It also outlines responsibilities for key people 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, local areas are encouraged to use this Framework and guidance as a toolkit to help them choose the most appropriate methodology for each individual case.

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]

Holding organisations and their leaders to account for the quality of services, and individuals to account for not meeting professional standards, are essential pre- requisites for public confidence in the national safeguarding system. Regulatory bodies for the professions hold this key role. Reviews are not designed for this purpose and will not be used in this way. Nevertheless, where reviews identify any actual or potential errors or violations, they should ensure that proper lines of accountability are followed to ensure that those responsible are held to account.

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;

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[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

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

Meeting the criteria does not mean a Local Child Safeguarding Practice Review must automatically be undertaken. Instead, the Rapid Review process outlined in this document will be followed to determine whether a review is appropriate (i.e. whether there is potential to identify improvements.)

Child safeguarding reviews may also be undertaken for cases which do not meet the definition of a 'serious child safeguarding case' if they raise issues of importance that could generate learning. *Working Together 2018*, for example, suggests they might take place where there has been good practice, poor practice or where there have been 'near miss' events.

In line with guidance from the National Panel, a Local Child Safeguarding Practice Review should be undertaken whenever potential local learning is identified. This may be a proportionate review. The National Panel strongly advises against undertaking any alternative non-statutory reviews.

However, there may be times where an alternative statutory review should be used: this could be a Domestic Homicide Review, a Safeguarding Adult Review, or a Multi-Agency Public Protection Serious Case Review. The case may also be considered by the statutory Child Death Review arrangements. *Appendix 1* provides a summary of the different statutory reviews.

Where there are links between cases, it may be appropriate to undertake a review that brings together the themes of these cases. This can lead to better system learning. However, it is crucial that the individual learning and the child's lived experience is not lost.

[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

Approach and Principles

GSCP 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.

GSCP will conduct Local Child Safeguarding Practice Reviews in line with good practice and the principles of the systems methodology recommended by the Munro Report.[5] This includes the advice outlined in *Working Together 2018* and its predecessor documents as well as the good practice principles described in the SCIE / NSPCC 'Quality Markers'[6]

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;
- 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.

Families, including surviving children, will be invited to contribute to reviews unless there is a strong reason not to. Steps will be taken to sensitively manage their expectations and ensure they understand how they are going to be involved.

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.

Strategic Leadership and Governance

The National 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

[5] The systems approach in this guidance was developed based on the model cited in the Munro Report: this is 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)
[6] Social Care Institute of Excellence (SCIE) and NSPCC's '*Serious Case Review Quality Markers: Supporting dialogue about the principles of good practice and how to achieve them'* (March 2016). Although these were developed for serious case reviews, most of the principles are transferable.

identification of cases, commissioning and supervising of reviews, and the publication of reports and embedding learning.

GSCP will convene a Child 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 National Panel, the Department for Education and Ofsted.[7]

2. 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:

[7] This is separate from the formal requirement on local authorities in England to notify the national Child Safeguarding Practice Review Panel and the relevant local safeguarding partners if a child dies or is seriously harmed in their area (or outside of England while they are normally resident in the local authority area) and their duty to notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected

- Identify how much information to share;
- Distinguish fact from opinion;
- Ensure that they give the right information to the right individual;
- Ensure that they share information securely;
- Where possible, be transparent with the individual, informing them that the information has been shared (as long as doing so does not create or increase the risk of harm);
- Record all information sharing decisions and reasons in line with organisational procedures.

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 Child 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.

3. 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.

A Rapid Review and decision on all referrals should be made within the timescales outlined in guidance from the National Panel (currently ***within 15 working days***) and 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 Child 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 National Panel and Secretary of State should be informed and provided with the reason for the delay

4. Deciding whether to Convene a Child Safeguarding Practice Review

REFERRAL

Agencies should inform the Safeguarding Partners (via the Business Manager), of any serious incident which they think should be considered for either a national or local Child Safeguarding Practice Review, using the *Referral Form (document 1).*

Local authorities have a separate duty to:

- notify the National Panel if a child dies or is seriously harmed in their area (or outside of England while they are normally resident in the local authority area);
- notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected.

Gateshead Council will notify any event that meets the above criteria to the Panel and the Safeguarding Partners ***within five working days*** of becoming aware that the incident has occurred and will also notify the Secretary of State and Ofsted where a looked after child has died, whether abuse or not neglect is known or suspected.

5. RAPID REVIEW

Rapid Reviews should assemble 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.

The Rapid Review must be completed within ***15 working days*** of becoming aware of the incident and submitted to the National Panel.

A flow chart setting out the key stages and suggested timescales is included at the end of this section – 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.

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 3*).

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 Safeguarding Partners 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:

- Gateshead 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 and agreed at this meeting.

CHAIRING THE RAPID REVIEW MEETING

The Rapid Review Meeting will be chaired by a member of the Case Review Group 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 CSPR Group chairperson, so if required they can oversee the commission and progress of the review.

Individual agencies should notify their own inspectorate bodies as required.

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

Rapid Review Process

Agency submits *CSPR Referral Form*

Within 2 working days of referral

- Initial Scoping and Information Sharing Template sent to all relevant agencies
- Date set for Rapid Review Meeting (Business Manager)

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 any 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
- Agrees any immediate action
- Considers the case against the criteria for a Local Safeguarding Practice Review
- Decides whether a practice review or other learning review should take place
- Completes the Rapid Review Template and agrees the recommendation

Within 2 days of the Rapid Review meeting

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

Within 5 days of Rapid Review Meeting

- Case Review Group Chairperson informed of the decision of the Rapid Review Meeting, including any proposed model, methodology and timescale for completion (RRM Chairperson)

6. Agreeing the Scope and Terms of Reference

The Child Safeguarding Practice Review Group, will formally agree the scope and terms of reference for the review. In order to do this, they may wish to make use of the Terms of Reference Template (Document 6) and will need to consider the following:

Time Period

The time period covered by the review should reflect the potential learning likely to be achieved. (There is little value in identifying weaknesses in professional practice or procedures that have already changed). It should, therefore, be as short and as recent as possible. This, however, needs to be balanced against the need to understand the pattern of child neglect and whether early help interventions could have been beneficial.

Focus of the Review

The Rapid Review is likely to identify the key lines of enquiry to be explored as part of the review. These will be confirmed and formally identified in the Terms of Reference. These may, however, be revised as more information becomes available. Any significant changes should be formally approved by the Child Safeguarding Practice Review Group.

Methodology

As set out in section 1 above, the local Safeguarding Partners are responsible for determining whether a review will take place and the methodology used. The 'systems approach' that will usually be adopted for Local Child Safeguarding Practice Reviews in Gateshead is described in Section 9. Each case will, however, be examined individually and the methodology may be adapted to meet the specific needs of the case. On occasion an alternative methodology may be used – see learning methodologies guidance

The Terms of Reference will specify the information collection and collation tools that will be used in the review. This may include Chronologies (of Key Events and/or organisational changes), Information Reports or both (see Section 9.2).

Engaging Children and Family Members

Using the information available, and the genogram where available (see Section 8), 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.

The information and support that children and family members are likely to require to effectively engage will also be identified.

Plans to engage children and family members will need to take into account any parallel investigations.

Parallel Investigations

The case may also be subject to a criminal or coroner's investigation, individual agency or professional body disciplinary procedures, and/or another type of formal review[8]. It is anticipated that a Local Child Safeguarding Practice Review will go ahead unless there are clear reasons not to.

5.6.2 Under Working Together 2018 there is greater discretion as to when a Local Child Safeguarding Practice Review should take place and who does it. This enables greater flexibility in designing the right review methodology whilst meeting 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.

Legal Advice

Consideration will be given to whether legal advice will be required at the outset or during the review.

Timetable

Taking into account the factors summarised above, the timetable for the review will be agreed. This will include the timing of Review Team meetings, Learning Events and engagement with families.

7. Appointing the Lead Reviewer and Review Team

The Lead Reviewer

[8] For example, Domestic Homicide Reviews, multi-agency public protection arrangement reviews, Safeguarding Adult Reviews or health 'serious untoward incident' processes.

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.

8. 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[9] 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.

[9] This includes, but is not limited to, the SCIE / NSPCC Quality Marker 4 on Informing the Family and Quality Marker 12 on Family Involvement

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 7) and Sample Leaflet on Child Safeguarding Practice Reviews (Document 8).

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.

9. 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 Gateshead. This is consistent with both the guidance in Working Together 2018 and the principles of the systems methodology recommended by the Munro Report.[10]

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.

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

[10] 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

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.

An example Chronology Template (Document 9) and Accompanying Letter (Document 10) are provided in the supporting documents, along with Guidance Notes on Completing the Chronology (Document 11).

Individual agency chronologies will be collated to produce an Integrated Key Events Chronology. This will often be colour coded to facilitate an 'at a glance' overview of agency involvement.

Information Reports

Information Reports can be used to analyse the agency's involvement with the child and family and any themes that have emerged. The report should outline any potential learning for the agency or for multi-agency arrangements and should include information about actions already undertaken.

An example Information Report Template (Document 12) and Accompanying Letter (Document 13) are provided in the supporting documents, along with Guidance Notes on Completing the Information Report (Document 14).

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

Using the chronologies and/or analysis in the Information Reports, 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 can be used to provide a forum for frontline professionals 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 15) 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 16).

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 17).

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 17a).

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;[11]
- 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.

[11] 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.

Practitioner 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.

This Practitioner Feedback may take place in a 'face to face' or virtual meeting, or through formal consultation.

10. The Report

The Report

Safeguarding Partners are required to publish the learning from all Local Child Safeguarding Practice Reviews. The Lead Reviewer will normally draft a formal report with publication in mind: Guidance on Drafting the Report, including good practice, is included as Document 18.

Reports should meet any requirements specified in the agreed Terms of Reference for the review and, as a minimum, should also succinctly include[12]:

[12]This guidance draws on national evaluations of best practice around Serious Case Reviews and the Practice Guidance issued by the National Child Safeguarding Review Panel on 5 April 2019

- 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.

Reports should be written in a way that avoids harming the welfare of any children or adults in the case. 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 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.

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

Identifying Recommended Improvements

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 some instances, the Lead Reviewer and Review Team may develop the formal recommendations. However, GSCP may choose to convene a dedicated group to consider the learning and how this can be developed into meaningful recommendations. These groups will be able to engage key strategic stakeholders 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.

11. Publication

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.[13]

Preparing for Publication

Publication and media planning will commence once the final report (including the agreed recommendations) has been formally endorsed by the GSCP. Publication planning will include strategic leads from the agencies involved in the review and their media/communication leads.

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.

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 should be identified. 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:

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

- 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 appropriate children's safeguarding website for the area.

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

12. 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[14]. 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

[14] 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.'

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

GSCP 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 19) is included in the supporting documents.

Taking into Account Learning from National Reviews

The relevant Child Safeguarding Practice Review Group will also review the learning from all national reviews and consider how it can be applied at a local level.

13. 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 Template
Document 5: Template Letter – Submitting the Rapid Review Template to the National Panel

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

Engaging Children and Family Members
Document 7: Template Letter – Informing Family Members of a Review
Document 8: Sample Leaflet – Local Child Safeguarding Practice Reviews

Methodology
Document 9: Sample Chronology Templates
Document 10: Template Letter – Request to complete a Chronology

Document 11: Guidance on Completing the Chronologies
Document 12: Information Report Template
Document 13: Template Letter – Request to complete an Information Report
Document 14: Guidance on Completing an Information Report
Document 15: Template Letter – Invitation to Reflective Learning Workshop
Document 16: Briefing Note on the role and purpose of Reflective Learning Workshops (to be sent as an appendix to Document 15)
Document 17: Sample Agenda for a Reflective Learning Workshop Document 17a: Example Worksheets for a Reflective Learning Workshop

The Report
Document 18: Guidance on Drafting the Report

Embedding Learning
Document 19: 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.