Northamptonshire Safeguarding Children Partnership

Child Safeguarding Practice Reviews Framework and Practice Guidance

December 2020

Northamptonshire Safeguarding Children Partnership

Contents

Who is this guidance for?

This practice guidance has been developed for all safeguarding partners, but in particular, those involved in undertaking or contributing to Child Safeguarding Practice Reviews, such as Independent Lead Reviewers, Review Groups, Authors 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 multi-agency safeguarding arrangements in Northamptonshire with a framework for the commissioning and dissemination of learning from Child Safeguarding Practice Reviews, along with guidance for practitioners involved in such reviews and is in accordance with the statutory guidance set out in *Working Together to Safeguard Children (2018).*

It describes the process and approach and key statutory elements of Child Safeguarding Practice Reviews and related processes along with templates and guidance for professionals in a suite of appendices.

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.

Child Safeguarding Practice Reviews are learning reviews and not designed to hold individuals and organisations to account for not meeting professional safeguarding standards. 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 to Safeguard Children 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. *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 Child Safeguarding Practice Review

Safeguarding Partners are required 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; and
- is one which the Child Safeguarding Practice Review 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.

Approach and Principles

- Each case will be considered on an individual basis.
- NSCP will conduct Child Safeguarding Practice Reviews in line with good practice.
- Decisions on whether to undertake a Child Safeguarding Practice Review will be transparent and the rationale shared with relevant partners.
- 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.
- All reviews will be conducted in a way which:
  a. reflects the child's perspective and family context;
  b. considers and analyses frontline practice as well as organisational structures and learning;
  c. establishes the reasons why events occurred as they did; and
  d. reaches recommendations 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.

Sharing Information

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.

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:

- 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 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 (or local equivalent) 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.

Referring a case for consideration of a Review – *See Appendix 1 for Template and supplementary guidance on completing the form*

Any professional within the partnership can submit a case for consideration of a Review.

The form will then be considered by members of the Rapid Review group, as detailed below, and a written response to the referral to advise of the recommendation made.

The outcome may be that a Rapid Review is recommended or that the learning has been identified and can be taken forward through specified mechanisms.

Serious Incident Notifications and Rapid Review – *see Appendix 2a for Serious Incident Notification and Rapid Review flowchart and Appendix 2b the Additional Information Request template including supplementary guidance on completing the request form*

The decision to submit a Serious Incident Notification (SIN) to the National Panel sits with the Local Authority and must be submitted to the National Panel within 5 days of the incident occurring. There are specific and prescriptive criteria that require submission of a Serious Incident Notification. It is the responsibility of the Local Authority to submit when:

- Abuse or neglect of a child is known or suspected; and
- The child has been seriously harmed.

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment

of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred

All agencies who have had involvement with the child or family will be required to contribute to the Rapid Review by providing relevant information. To support this, an Additional Information template will be provided along with guidance for practitioners. *See Appendix 2b.*

Professionals are required to complete and return the Additional Information template **within 7 working days** of the date the request is made.

A Rapid Review meeting will take place as soon as the Additional Information is collated and a recommendation made. This report is then presented to Strategic Leads for their decision and then the report submitted to the National Panel **within 15 working days**.

The Rapid Review meeting consists of:

- Designated Doctor for Safeguarding Children, Northamptonshire Clinical Commissioning Group – and Chair of Local Learning Review Sub Group;
- Head of Child Protection Team, Northamptonshire Police;
- Service Manager, Northamptonshire Children's Trust; and
- Any other specialist professional as identified.

The Rapid Review meeting should:

- review the facts about the case as presented in the partner's provided documentation;
- discuss whether any immediate action is needed to ensure children's safety;
- identify immediate learning that can be acted upon;
- consider the potential for identifying improvements to safeguard and promote the welfare of children; and
- make a recommendation on whether the case requires a Child Safeguarding Practice Review if there is significant more learning to be identified.

If it is deemed that all relevant learning has been identified, this will be taken forward by appropriate actions and a 6 step learning briefing developed for the purpose of dissemination across the partnership and for discussion within team meetings.

If the decision is for a Child Safeguarding Practice Review to be undertaken, a 6 step learning briefing will be created to help inform learning and be disseminated within appropriate teams.

Overview and Timescales

Reviews will vary in their scope 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**).

All statutory Child Safeguarding Practice Reviews should be completed no later than **six months** from the date of the decision to initiate a review.

Sometimes the complexity of a case does not become apparent until the review is underway. 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 Local Learning Review Sub Group and Strategic Leads as soon as they arise. If the delay will prevent the publication of the final report within six months, the National Panel should be advised.

Practitioner engagement – *see Appendix 3 for supplementary guidance for practitioners*

Practitioner engagement and contributions to a Child Safeguarding Practice Review is essential and helps inform the Review Group to understand the situation and decision making of individuals.

Due to multiple handovers within Children's Services, we need to make sure that new workers / teams are notified to NSCP so they are not left out.

It is important for managers to encourage their staff to attend these events and for practitioners to understand these events are a safe environment for them to speak openly and honestly about the case and relevant events.

Family engagement

When the decision has been made to undertake a Child Safeguarding Practice Review the immediate family (parents) are informed. Each case is considered as to whether other family members need to be included.

Parents are informed by letter and if possible, this will be delivered by a practitioner they are already familiar with, often via their allocated Social Worker. Parents will be asked for consent for the Review Group to be able to access their medical records and they will be given the opportunity to contribute to the review by speaking with the Lead Reviewer and / or a further member of the Review Group.

Mid-process, a further letter will be sent to parents (and other family members if deemed a requirement) to further invite and encourage them to contribute to the review.

When a review is concluded, parents (and other family members if they have participated in the review process) are given the opportunity to hear the findings of the review from the Lead Reviewer, immediately prior to publication.

Family engagement will form part of every Review Group meeting and a genogram will be developed at the outset to understand the family's structure.

Role of Independent Scrutineer

Northamptonshire Safeguarding Children Partnership commissioned an Independent Scrutineer to challenge and scrutinise safeguarding arrangements in the county.

Their role in this process will be:

- Help inform the decision made at the Rapid Review;
- Attend the Initial Review Group meeting to create Terms of Reference per Child Safeguarding Practice Review; and
- Review the initial draft of the Overview Report to help inform the Review Group discussions.

Developing Terms of Reference and Establishing Key Lines of Enquiry

Following the Strategic Lead decision to undertake a Child Safeguarding Practice Review, a Review Group *(historically referred to as the Panel)* will be established to support the Lead Reviewer.

The first meeting of the Review Group will focus on scoping the Terms of Reference for the review and establishing key lines of enquiry, which will be supported by observations made by the Independent Scrutineer and the Rapid Review report.

Commissioning a Lead Reviewer

A Lead Reviewer will be appointed to manage the review process, chair meetings of the Review Group, facilitate the Practitioner Event and author the final Overview Report.

NSCP Business Office will inform the National Panel, Ofsted and the Department for Education that a Child Safeguarding Practice Review has been commissioned and the name of the Lead Reviewer commissioned via email to:

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

Establishing a Review Group

The Review Group will be made up of a representative from each of the three Strategic Lead agencies:

- Northamptonshire Children's Social Care;
- Northamptonshire Clinical Commissioning Groups; and
- Northamptonshire Police.

The Review Group will also include representation from two further partner agencies (one of whom will not have had any involvement with the family the review is about).

Outline of Methodology *– see Appendix 4a for CSPR Process Flowchart, Appendix 4b for Key Events Analysis Report template and Appendix 4c for Chronology template*

The Rapid Review will identify initial learning and concerns to inform discussions at the first Review Group meeting where Terms of Reference will be set out, along with key lines of enquiry. This meeting will also be informed of the views of the Independent Scrutineer.

Following the initial Review Group meeting to set the Terms of Reference, an Author briefing will take place that will include the Review Group members where the agreed Terms of Reference will be discussed and expectations set out for authors.

Authors will be provided with the necessary templates and supplementary guidance, along with a time frame for completion *(please see Appendices 4b and 4c).*

Practitioner Event *– see Appendix 5a for practitioner event guidance and Appendix 5b for Guidance for Managers*

Parallel Processes *– see Appendix 6 for Parallel Process Guidance*

Analysis and Recommendations – *see Appendix 7 for supplementary guidance*

Overview Report

Following the submission of agency chronologies and Analysis Reports and Practitioner Event, the Lead Reviewer will draft a first version of the Overview Report. This will be considered by the Review Group and Independent Scrutineer for comment and revision.

A revised Overview Report will then be considered by the Local Learning Review Sub Group for comment, any revision and agreement before being presented to Strategic Leads.

All Overview Reports are anonymous with no identifiable child or family information provided.

Sign off process

Once the Overview Report has been agreed by the Review Group and Local Learning Review Sub Group, it will be presented to strategic Leads for consideration and final sign off.

Once this has taken place, the Overview Report will be submitted to the National Panel for consideration information. The National Panel will acknowledge the Overview Report and may provide feedback to Strategic Leads; however, this is in a guidance capacity only.

Practitioner de-brief

Two Practitioner de-briefs, delivered by the Lead Reviewer, will be held within a couple of days of scheduled publication.

- The first will be for practitioners directly involved in the review and will be conducted in a manner that is sensitive to their needs.
- The second will be an open event for any practitioner keen to hear the findings from the review and empower their learning.

Publication

Working Together to Safeguard Children 2018 states that publishing Overview Reports is expected, therefore, all reports should be written in a manner for publication.

The National Panel should be informed of the publication date and receive the final version of the Overview Report at least 14 days prior to the publication date.

Elected Council members are informed of the publication date and a briefing provided.

Publication is managed by NSCP Communications Sub Group who will create a press statement that is circulated to press members approximately 2 days prior to publication and inviting them to a 1:1 interview with representatives of the NSCP (Strategic Leads or their delegates).

Overview Reports are made available on the NSCP website on the agreed day of publication – usually around 10:00 hours.

Appendix 1

Northamptonshire Safeguarding Children Partnership

Request Form for Consideration of a Review by NSCP Local Child Safeguarding Practice Review Sub Group

Working Together 2018 provides clear criteria when Northamptonshire Safeguarding Children Partnership (NSCP) should conduct a Child Safeguarding Practice Review (CSPR).

Each agency should ensure that serious incidents which may meet the criteria for a CSPR or Case Mapping Exercise are brought to the attention of the NSCP using this form.

When completing this form please ensure **all boxes** are completed. The form MUST be signed off by your Senior Manager for Safeguarding before submitting to the NSCP Business Office.

Please note if any boxes are left empty, the request will be returned to you for completion.

Please send the completed form to:

Safeguarding Project Officer via the NSCP Inbox
Email: NSCB@northamptonshire.gov.uk

REFERRER

NAME	AGENCY & DESIGNATION	CONTACT DETAILS – Address, telephone number and e-mail address
Signed:		**Dated:**

SENIOR MANAGER FOR SAFEGUARDING

NAME	AGENCY & DESIGNATION	CONTACT DETAILS – Address, telephone number and e-mail address
I agree with this request for consideration of a review **Signed:**		**Dated:**

Date submitted to the Business Office:	

Northamptonshire Safeguarding Children Partnership

Please indicate what type of review you are requesting consideration for:

☐ **Child Safeguarding Practice Review (CSPR)**

Serious child safeguarding cases are 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) serious **and/or** long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.*

☐ **Case Mapping Exercise (CME)**

The case does not fit the criteria for a Child Safeguarding Practice Review as set out above, but there is significant multi-agency learning to be identified.

Please provide rationale to support your request in accordance with *both of* the above criteria. Please note that a CSPR should only be requested where the criteria are met. It is not a legitimate response to concerns about poor practice where death or serious harm have not occurred. In these circumstances, the formal escalation protocols should be used.

Northamptonshire Safeguarding Children Partnership

CHILDS DETAILS

Name of Child	
Date of Birth	
Date of Death or; Date of Serious Incident	Death: \ \ Serious Incident: \ \
Home Address	
Previous Addresses	
Ethnic Origin	
Faith/Religion	
Is the child/young person subject to a child protection plan or has been previously? (If so when, for what and for how long?)	
Address of location of incident	
Carer at time of incident	
Is this case known to be the subject of a criminal investigation? (If so who is the lead investigator?)	
Are there any adult safeguarding concerns and have these been shared with NSAB? (If so who is the key contact?)	

FAMILY DETAILS

Name	Relationship to Child	Date of Birth	Address	Ethnic Origin	Are they subject to a child protection plan or have they been previously?*

* If so when, for what and for how long?

OTHER AGENCIES KNOWN INFORMATION

Agency	Contact Details –Address, Telephone and E-mail	Reason for involvement
Children First Northamptonshire Fostering: Adoption Leaving Care: Looked After Child: Early Help: Child Protection:		
MASH:		
Education:		
Northamptonshire Police		
Clinical Commissioning Groups GP: Kettering General Hospital: Northampton General Hospital: Northamptonshire Healthcare Foundation Trust:		
National Probation Trust – Northamptonshire		
BeNCH CRC		
Other		

CHRONOLOGY

Please use the chronology table below to outline any events around the time of the incident.
PLEASE NOTE: This should only include key events and DOES NOT need to be a detailed chronology at this stage.

Date and Time	Event

FOR INTERNAL USE ONLY

To be completed by the Business Office once considered

Is a Review recommended or not?	Yes ☐ No ☐
If so what type of Review?	☐ Child Safeguarding Practice Review ☐ Case Mapping Exercise
Comments	
Date of recommendation	

REASON FOR RECOMMENDATION

Has legal advice been sought?	Yes ☐ No ☐

NSCP STRATEGIC PARTNERS DECISION

Is a review agreed	Yes ☐ No ☐
Comments	
Date agreed with recommendation	\ \

Appendix 2a

Northamptonshire Safeguarding Children Partnership

Rapid Review – Process Flowchart

Need 2 Know form / partner request for type of review identifies criteria is met for Ofsted notification (Asst. Director / SQAS Strategic Manager decision).

Serious Incident Notification (SiN) is sent to Ofsted & NSCP Business Office by SQAS Strategic Manager / nominated representative within 5 days of the incident.

Ofsted share the SiN report with CSPR National Panel and other arms of the regulator

NSCP requests additional information from all partners; for Children's Trust, this will be completed by Auditor or relevant Service Manager, overseen by AD (Safeguarding)

All relevant agencies Rapid Review summaries must be completed and returned to NSCP within 8 working days. The form consists of basic data, chronology, analysis, learning and recommendations.

Rapid Review Panel is convened 10 – 13 days following the initial SiN.
Rapid Review Panel consists of the LLR Sub Group Chair & Strategic Lead agency representatives:

Jane Napier – Chair CCG
Matthew Howarth – Police
Maxine Clark – Children's Trust

Panel makes a recommendation for action based on analysis of the evidence. This will be either: 1. Learning is taken forward through the Rapid Review process or 2. The case fits the criteria for a CSPR

Panel recommendation is reviewed by Strategic Leads and final feedback of collated Rapid Review form is submitted to the National Panel - by day 15 of incident.

National Panel respond with feedback 2 – 4 weeks from receipt of Rapid Review recommendation*

* Following identification of any actions required through the Serious Incident Notification process or arising from any subsequent review, Northamptonshire Children's Trust (NCT) will identify any new single agency resources or responses needed to address that action;

- If the proposed action requires a new procedure or amendment to a current NCT procedure, this will be drafted by relevant NCT managers and approved through SLT. This detail / information will then be cascaded as 'Learning from Reviews';
- If the action requires a bespoke training or learning programme, The Social Work Academy will review the proposed action against current guidance and expected practice(s) and will coordinate a training / learning programme to deliver the action;

New or amended procedures and commissioned training programmes will be reported in each ¼ly QA summary report;

The Academy and QA Managers will track actions resulting from the SiN / review process to monitor completion and impact and will feedback this detail to the NSCP.

Appendix 2b

Northamptonshire Safeguarding Children Partnership

Additional Information request

SECTION 1

1.1 BRIEF INFORMATION

CHILDS DETAILS

Name of Child	
Date of Birth	
Date of Death or Serious Incident	
Home Address	
Ethnic Origin	
Faith / Religion	
Disability	
Is the child / young person subject to a child protection plan or has been previously? (If so when, for what and for how long?	
Address of location of incident(s)	
Carer at time of the incident	
Is this case known to be the subject of a criminal investigation?	

1.2 FAMILY DETAILS

Either insert Genogram, or complete these boxes.

Name	DoB	Address

2.1 BACKGROUND TO THE INCIDENT

Please provide a brief summary of the history of concerns and regarding the actual incident that has led to this request for consideration of a review.

Northamptonshire Safeguarding Children Partnership

SECTION 2

2.2 ORGANISATIONS KNOWN INVOLVEMENT AT THE TIME THE INCIDENT

Agency	Reason for involvement (in brief)

SECTION 3

3.1 ANALYSIS

Please provide details of analysis of your agency involvement regarding this case and your rationale for submitting the case for consideration of a review.

3.2 AREAS OF LEARNING

SECTION 4

THEMES / ISSUES

Please detail:

- Any actions taken as a result of learning
- Good practice

Appendix 3

Child Safeguarding Practice Reviews - engaging and supporting frontline practitioners

Purpose of this guidance:

One of Northamptonshire Safeguarding Children Partnership's (NSCP) core principles when undertaking Child Safeguarding Practice Reviews (CSPR) is that practitioners are fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith (Working Together 2018). This guidance is intended to support NSCP's partner agencies to follow best practice to ensure that practitioners are facilitated and supported to contribute to case learning. This should be reflected in the analysis of learning undertaken by individual partner agencies in relation to their own involvement. The partnership as a whole will learn from cases most effectively when practitioners are enabled to share their experience of the case "on the ground" at the practitioner learning event which will be a key part of the review process in all CSPRs.

The importance of practitioner views to inform case learning

Historically learning from serious cases has typically focused on reviews of case records, and particularly on whether formal written safeguarding procedures have been adhered to.

Where case learning is limited to a review of written records, it is very likely that this will not capture the complexity of the experience of practitioners "on the ground" when trying to maintain engagement, undertake assessments and support families with multiple, complex needs.

Where concerns are raised about practice, it is important that practitioners are able to speak freely about their experience of the case and challenges or barriers there might have been when considering, for example making a child protection referral, or challenging a decision to step down the case in a child protection conference.

For example, there may be many practical barriers to effective communication and information sharing. Practitioner decisions may be strongly influenced by a concern that a decision to make a child protection referral may not meet thresholds and might lead to disengagement by the family.

If many practitioners experience the same challenges and barriers, practice is unlikely to change if these are not taken into account in the analysis of the case or in the development of recommendations.

Perhaps even more importantly, any effective practice, perhaps during a previous period of involvement, which has increased the safety and well-being of children and supported family functioning needs to be recognised and understood. Developing our understanding of "what works" may ultimately be more powerful in strengthening the work of independent practitioners and of services to change outcomes.

The impact of serious safeguarding incidents on practitioners

It is essential that the potential psychological impact on practitioners of being involved in the case with a very adverse outcome is recognised. Appropriate support for practitioners involved in such cases is essential, not just the practitioner well-being but also for wider workforce reasons. Case involvement in such situations may trigger a decision to retire or transfer to another area of work. This can mean that experienced practitioners who have worked within teams, and a multiagency context, to support children and families over the years, may be lost to the workforce.

CSPR practitioner events

A Practitioner event will be scheduled within the course of the CSPR, where the emerging findings of the case will be shared. This opportunity to "see the whole picture" is extremely powerful for individual learning. It will typically present a picture of the lived experience of the child which may be distressing to hear for the first time, which will be the case for many practitioners who have only seen certain aspects of the experiences of the child and family. It will also often make it clear that significant information was held by practitioners in different agencies and that effective communication and joint assessment might have changed the outcome for a child.

The practitioner event will be facilitated in such a way that practitioners are asked to contribute to learning focused on improving practice, rather than identifying failings - which will have been shared as part of the presentation of the case and emerging learning.

NSCP partner agencies are asked to:

- Identify relevant case involved practitioners who should attend the practitioner event
- Ensure wherever possible that practitioners freed from other duties in order to be able to attend
- Ensure that practitioners have access to appropriate supervision and support before and after the practitioner event.
- Refrain from requesting that Senior service managers not directly involved in the case review participate in the practitioner event. The intention is that practitioners should be able to speak openly about any concerns they may have, which might include concerns about team capacity structure, supervision and other issues.

Where events are held "virtually" it must be recognised that practitioners may be isolated e.g. working from home, when potentially very distressing information about the lived experience of children, and professional and organisational failings is shared.

Where a practitioner does not feel that they would be able to participate in the practitioner event, it may be appropriate for a first-line manager to attend, to share the practitioners case experience as appropriate. In some cases, it may be appropriate to arrange a one-to-one discussion with the lead review. The NSCP business office will facilitate this.

Appendix 4a

Northamptonshire Safeguarding Children Partnership

Child Safeguarding Practice Review Flowchart

STAGE 1: NOTIFICATION AND CONSIDERATION (RAPID REVIEW)

Serious Incident Notification or a request for consideration of a review received

Case referred to the Rapid Review Panel and a Rapid Review is conducted **within 15 days.**

Additional Information template sent to relevant agency leads
Returns disseminated to Rapid Review Panel to read/analyse ahead of Rapid Review Meeting.

Rapid Review meeting is held.
NSCP makes recommendation to the NSCP Strategic Leads, including type of review/methodology. Input from Independent Scrutineer

STAGE 2: CHILD SAFEGUARDING PRACTICE REVIEW

Local Child Safeguarding Practice Review commissioned
- Commission of Independent Reviewer

Initial Scoping Review Group meeting:
- Terms of Reference drafted
- Key lines of enquiry identified
- Parallel processes identified (if applicable)
- Agency report authors identified

Information gathering from agencies: -
- Key Events Analysis Report and Chronology template sent to Agency report authors identified

Practitioners Event and engagement with family

Review Group meeting to scrutinise the information received from the Agencies.

Review Group meeting to receive first draft of Overview Report.
- The Overview Report will also go to the LLR Sub Group for additional scrutiny.

2nd Review Group meeting to review updated Overview Report
- With a focus on smart recommendations

Extraordinary Board Meeting to agree Final Report

Practitioner debrief

Final Publication

Appendix 4b

Northamptonshire Safeguarding Children Partnership

Child Safeguarding Practice Review

Child xx

Key Event Analysis and Learning

AGENCY ..... *Please complete*

Section 1

Author's name:	
Author's signature:	
Date:	

Agency manager name:	
Agency manager signature:	
Date:	

Please note it is mandatory that all above boxes are completed prior to submission OTHERWISE your report will not be accepted.

Report revision

Author's signature	
Agency manager signature:	
Date:	

Section 2

Guidance notes for completion of Section 2:

1. *From your completed chronology, please identify key critical events.*
2. *In the boxes below, please provide an in-depth analysis of the key event highlighting any gaps in practice, the reason for the gap and what should have happened.*
3. *Please provide the learning for your agency under each key event.*
4. *Please provide details of what has already been done to address the learning and any outstanding actions.*
5. *Please provide evidence of how the change in practice has affected front line working with a specific case example.*

IT IS A MANDATORY BOX THAT ALL BOXES PER EVENT ARE COMPLETED

Date and title of key event	
In-depth analysis	
Learning	
How has learning been addressed to date	
Outstanding action	
Evidence 'so what'	

Please copy and paste the above box for however many entries you have.

Section 3

IT IS MANDATORY THAT SECTION 3 IS COMPLETED

Mid-way through a Child Safeguarding Practice Review a Practitioner Event is held to allow practitioners who have been involved in the case to come together for a multi-agency discussion to identify learning and good practice.

Please provide names and email addresses of all colleagues who have been involved in this case and will be invited to attend a Practitioner Event.

Practitioner's name	Title	Email address

Please add further lines as required

Appendix 4c

Northamptonshire Safeguarding Children Partnership

Chronology for [ ]

Timeline: [ ]

Guidance for completion:

* Please do not add or remove any columns.
* Please use the guidance in red under each column heading
* Please ensure you complete the MANDATORY column for every appropriate entry
* Please note the size of cells in Excel is limited, therefore if you are adding a lot of narrative, please split over several lines.

Date	Time	Agency	Summary of entry	Outcome of event	MANDATORY: Critical Analysis of event
Please use format : 01/01/18	Please use 24 hour clock: eg 18:24	Please use consistent agency title for every entry	Please add where the communication has come from (include professional's name and agency), name of family member it is related to and where it is recorded	Please provide details of the outcome of the entry - what action was due to be undertaken and did it happen or not	Please include information where relevant: Was this standard practice? Was this good practice? If not, what should have happened? What learning have you identifed and how has this been addressed?

Appendix 5a

Child Safeguarding Practice Reviews - engaging and supporting frontline practitioners

Purpose of this guidance:

One of Northamptonshire Safeguarding Children Partnership's (NSCP) core principles when undertaking Child Safeguarding Practice Reviews (CSPR) is that practitioners are fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith (Working Together 2018). This guidance is intended to support NSCP's partner agencies to follow best practice to ensure that practitioners are facilitated and supported to contribute to case learning. This should be reflected in the analysis of learning undertaken by individual partner agencies in relation to their own involvement. The partnership as a whole will learn from cases most effectively when practitioners are enabled to share their experience of the case "on the ground" at the practitioner learning event which will be a key part of the review process in all CSPRs.

The importance of practitioner views to inform case learning

Historically learning from serious cases has typically focused on reviews of case records, and particularly on whether formal written safeguarding procedures have been adhered to.

Where case learning is limited to a review of written records, it is very likely that this will not capture the complexity of the experience of practitioners "on the ground" when trying to maintain engagement, undertake assessments and support families with multiple, complex needs.

Where concerns are raised about practice, it is important that practitioners are able to speak freely about their experience of the case and challenges or barriers there might have been when considering, for example making a child protection referral, or challenging a decision to step down the case in a child protection conference.

For example, there may be many practical barriers to effective communication and information sharing. Practitioner decisions may be strongly influenced by a concern that a decision to make a child protection referral may not meet thresholds and might lead to disengagement by the family.

If many practitioners experience the same challenges and barriers, practice is unlikely to change if these are not taken into account in the analysis of the case or in the development of recommendations.

Perhaps even more importantly, any effective practice, perhaps during a previous period of involvement, which has increased the safety and well-being of children and supported family functioning needs to be recognised and understood. Developing our understanding of "what works" may ultimately be more powerful in strengthening the work of independent practitioners and of services to change outcomes.

The impact of serious safeguarding incidents on practitioners

It is essential that the potential psychological impact on practitioners of being involved in the case with a very adverse outcome is recognised. Appropriate support for practitioners involved in such cases is essential, not just the practitioner well-being but also for wider workforce reasons. Case involvement in such situations may trigger a decision to retire or transfer to another area of work. This can mean that experienced practitioners who have worked within teams, and a multiagency context, to support children and families over the years, may be lost to the workforce.

CSPR practitioner events

A Practitioner event will be scheduled within the course of the CSPR, where the emerging findings of the case will be shared. This opportunity to "see the whole picture" is extremely powerful for individual learning. It will typically present a picture of the lived experience of the child which may be distressing to hear for the first time, which will be the case for many practitioners who have only seen certain aspects of the experiences of the child and family. It will also often make it clear that significant information was held by practitioners in different agencies and that effective communication and joint assessment might have changed the outcome for a child.

The practitioner event will be facilitated in such a way that practitioners are asked to contribute to learning focused on improving practice, rather than identifying failings - which will have been shared as part of the presentation of the case and emerging learning.

NSCP partner agencies are asked to:

- Identify relevant case involved practitioners who should attend the practitioner event
- Ensure wherever possible that practitioners freed from other duties in order to be able to attend
- Ensure that practitioners have access to appropriate supervision and support before and after the practitioner event.
- Refrain from requesting that Senior service managers not directly involved in the case review participate in the practitioner event. The intention is that practitioners should be able to speak openly about any concerns they may have, which might include concerns about team capacity structure, supervision and other issues.

Where events are held "virtually" it must be recognised that practitioners may be isolated e.g. working from home, when potentially very distressing information about the lived experience of children, and professional and organisational failings is shared.

Where a practitioner does not feel that they would be able to participate in the practitioner event, it may be appropriate for a first-line manager to attend, to share the practitioners case experience as appropriate. In some cases, it may be appropriate to arrange a one-to-one discussion with the lead review. The NSCP business office will facilitate this.

Appendix 5b

Northamptonshire Safeguarding Children Partnership

CSPR Practitioner Event Guidance for Managers

Aims

To share a summary of the case, with a focus on the lived experience of the child, and emerging findings and thematic learning.

To allow participants who have individual knowledge of the case to see the "big picture" with information held by other agencies, which might not have been previously known to them.

To capture the experience of practitioners working "on the ground" with a particular focus on hearing their views about barriers to engaging with families, helping family to access support and make changes, and to working effectively with colleagues from different agencies. Conversely, to hear about factors that have supported or facilitated work with the family in this case, or families experiencing similar difficulties.

To contribute to the development of recommendations which will support frontline safeguarding practice, with a strong focus on how this might improve outcomes for families, and how we will know that we have achieved this

Participants

Partner agencies are asked to identify appropriate participants. The practitioner event in the Child Safeguarding Practice Review is intended for frontline practitioners from the teams who have been directly involved in the case. Team managers/facilitators may be asked to attend where they can help present the experience of frontline practitioners who cannot attend directly. Senior service managers are asked not to attend this event. It is expected that safeguarding leads will participate with the focus on supporting frontline practitioners.

Supporting participants

Partner agencies should ensure that practitioners who wish to attend are enabled to do so i.e. that they are free from other work commitments at that time.

The information shared in a practitioner event can be distressing to hear, particularly when practitioners who have worked with the child and family hear information which was known to other agencies but not previously to themselves.

Agencies should ensure that participants will have access to appropriate support if needed, both prior to and after the practitioner event. It is particularly important to ensure that practitioners who may be participating virtually, and therefore may be working from home or office in isolation.

By this stage, it is likely that failures in effective multi-agency safeguarding have been identified through the review process, and these will be shared with participants. The aim of the practitioner event is not to a apportion blame to individuals, teams and services, but to consider how we might work better together to support children and families.

The lead review and the review team will have identified questions and issues that might be useful to consider during the practitioner event. These will be circulated to intending participants in advance of the event. It is recommended that practitioners meet with team managers and/or safeguarding needs to begin to develop ideas about how support to families could be improved.

Practitioners who have had significant case involvement will not be required to attend if they consider that this might be too distressing for them. These individuals may well have the most relevant experience to help the review team understand the barriers to effective safeguarding in this case and it is important that these are shared, for example by a team manager, at the practitioner event. It may be appropriate for key individual frontline practitioners with case involvement to have a one-to-one meeting or discussion with the lead review.

Once again we would like to highlight that practitioners with direct case involvement should receive appropriate support throughout the process of the case review.

Appendix 6

Northamptonshire Safeguarding Children Partnership

Parallel processes

When a child has died been seriously harmed through abuse or neglect, a number of parallel investigations and case reviews may need to take place, alongside a Child Safeguarding Practice Review. These can include:

- Criminal investigations and prosecutions
- Care proceedings in the Family Proceedings Court
- Single agency reviews such as Serious Incident reviews within health services or Case Mapping in the Children's Trust
- On-going active statutory case management for the child and / or siblings or
- Disciplinary processes

It is a general principle that any parallel investigations and reviews should not normally raise any significant barriers around sharing information required by the child safeguarding practice review, and in particular there should be no barrier to sharing information from agency records. However, in some specific circumstances parallel processes may impact on practitioner engagement, and/or the engagement of family members with the child safeguarding practice review. Ongoing criminal investigations or prosecutions may require a delay in publication of completed reviews.

NSCP's approach to managing the interface between CSPR's and any parallel processes is as follows:

Criminal investigations and prosecutions:

The LLR subgroup representative for Northamptonshire police will keep the NSCP business office updated about any criminal investigations and prosecutions, and will also ensure that the business office has the contact details of the Officer in Charge of the case.

The business office will provide the OIC with the terms of reference of the CSPR, and will notify them of the date of any practitioner event, and the lines of enquiry to be explored at practitioner event. The OIC will also be invited to participate in the practitioner event. The business office will also liaise with the OIC regarding any restrictions on family engagement, when there is or may be a criminal investigation or prosecution. We will not expect to publish any final overview report until the completion of any prosecution.

Care proceedings in the Family Proceedings Court

The LLR representative for the Children's Trust will keep the NSCP Business Office updated about the conduct of any proceedings in the Family Proceedings Court, including findings and outcomes for the child or any associated siblings. The Children's Trust LLR representative will make sure that the Business Office has current details of the allocated Social Worker's team. The allocated Social Worker and their Team Manager will be invited to participate in the practitioner event, along with any other workers who have had significant engagement with the child / family. The business office will also liaise with the allocated Social Worker with regard to progress and outcome of any planning processes (Targeted Support / CiN / CP / CiC or Care and permanence proceedings).

Single agency reviews, on-going case management and disciplinary processes:

LLR subgroup members will be expected to inform the NSCP business office of any parallel processes in relation to any case which is the subject of a child safeguarding practice review. In general, we

expect that such parallel processes will not interfere with the process of a CSPR. We recognise that such processes could have an impact on how one or more key practitioners may participate in a review, if their individual practice is being subject to critical scrutiny, LADO investigation or disciplinary review. In such situations, it is still important that the review can be informed as much as possible by the experience of front line practitioners. This will be addressed on a case by case basis through discussion between the lead review, any relevant agency members of the review panel, and relevant agency safeguarding leads.

Case Mapping is a collective, historic review of activities and actions that informs current case planning; it is a live planning process and needs to be informed by all relevant information available, including internal and multi-agency enquiries.

Similarly, LADO investigations and findings will be informed by all contributing partners' investigation outcomes, including any disciplinary enquiries.