******Guidance on Safeguarding Reviews for Children and Adults**

**Name of Author: Anita Hiller**

**Name of Senior Manager Approving: Pritpal Sodhi**

**Date of Issue: January 2024**

**Date to be Reviewed: January 2025**

|  |  |
| --- | --- |
| **Contents** | **Page** |
| [Child Safeguarding Practice Review Panel and Safeguarding Children Multi-Agency Partnerships](#_Child_Safeguarding_Practice) | 3 |
| [Notifications to National Panel](#_Notifications_to_National) | 3 |
| [Agency Involvement Summary Report](#_Agency_Involvement_Summary) | 6 |
| [Rapid Review](#_Rapid_Review) | 6 |
| [Independent Management Review reports (IMR)](#_Independent_Management_Review_1) | 8 |
| [Local Child Safeguarding Practice Review (LCSPR)](#_Local_Child_Safeguarding_1) | 8 |
| [Practitioner Events](#_Practitioner_Events) | 9 |
| [Internal Reviews](#_Internal_Reviews) | 10 |
| [Child Death Process](#_Child_Death_Process) | 10 |
| [Safeguarding Adult Reviews](#_Safeguarding_Adult_Reviews) | 12 |
| [Domestic Homicide Reviews](#_Domestic_Homicide_Reviews) | 13 |
| [Guidance for the allocated practitioners, managers, and teams, where a safeguarding review is being completed on a child or their parent](#_Safeguarding_Review_(SR)) | 14 |
| [Appendix 1 - Glossary](#_Appendix_1_–) | 16 |
| [Appendix 2 - Roles and Responsibilities](#_Appendix_2_-) | 18 |
| [Appendix 3 - Advice for practitioners or managers where a safeguarding review is being completed on a child or their parent](#_Appendix_3_-) | 20 |
| [Appendix 4 – Guidance for Authors of Agency Involvement Summary Reports, Internal Reviews and Independent Management Reviews](#_Appendix_4_–) | 21 |
| [Appendix 5 - KSCMP Flowchart](#_Appendix_5_-) | 22 |

This guidance should be read in conjunction with:

[Need to Know Notifications and Alerts](https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fproceduresonline.com%2Ftrixcms2%2Fmedia%2F21192%2Fneed-to-know-notifications-and-alerts.docx&data=05%7C02%7CAnita.Hiller%40kent.gov.uk%7C57a44a80faf2423f375b08dc21862c4d%7C3253a20dc7354bfea8b73e6ab37f5f90%7C0%7C0%7C638422107350402119%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=kAmKakNcHC8Q0zqyq3DyPbyTh4eIEhf0zucVkCteFbQ%3D&reserved=0)

[Working Together to Safeguard Children 2023](https://assets.publishing.service.gov.uk/media/65803fe31c0c2a000d18cf40/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf)

[Kent Child Death Overview process](https://www.kscmp.org.uk/procedures/child-death-overview-process)

[Child Safeguarding Practice Review Panel guidance for safeguarding partners](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1108887/Child_Safeguarding_Practice_Review_panel_guidance_for_safeguarding_partners.pdf)

[Strategy Discussion Guide](https://www.delta-learning.com/pluginfile.php/79771/course/section/21892/Strategy%20Discussion%20Guide.docx)

This guidance explains the process within Kent Integrated Children’s Services following a notification to the Child Safeguarding Practice Review Panel (also known as National Panel). This includes the role of the Safeguarding, Professional Standards and Quality Assurance Unit (SPSQA), the District Teams/Services and the role of Safeguarding Children Mult-agency Partnerships.

# Child Safeguarding Practice Review Panel and Safeguarding Children Multi-Agency Partnerships

The CSPR Panel is responsible for identifying and overseeing how the national child protection system and multi-agency partners learn the lessons from serious child safeguarding incidents, which in its view, raise issues that are of complex national importance**.**

Kent Safeguarding Children Multi-Agency Partnership (KSCMP) must make arrangements locally to identify and review serious child safeguarding incidents, which in their view raise issues of importance in relation to their area and make a referral to the National Panel.

# Notifications to National Panel

Section 16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) places a duty on all local authorities to notify the Child Safeguarding Practice Review Panel of incidents where a local authority knows or suspects a child was abused or neglected if:

1. the child dies or is seriously harmed in the local authority’s area
2. while normally resident in the local authority’s area the child dies or is seriously harmed outside England

For the level of harm to be serious, this must be a life-changing injury, long-term impairment resulting from an injury, or be life-threatening.

In cases of physical injury, which are neither life-threatening nor life-changing, consideration should be given to the extent, persistence and severity of the injuries sustained and any context of wider neglect or abuse. Isolated bruises or limb fractures in infants or children would not normally be considered serious unless accompanied by internal injuries (for example, abusive head trauma or abdominal injuries) or these are of a degree or extent likely to be life-threatening or life changing.

A [Strategy Discussion](https://www.proceduresonline.com/kentandmedway/chapters/p_strat_discus.html) must be held when there are concerns of significant harm to a child. The relevant and most appropriate professionals should be invited including Police and Health to inform decision making by providing information, updates and reports on the harm the child has suffered, whether the harm is life changing, there is long term impairment, or it is life-threatening, and, if it is likely due to the care received. This information will not only inform decisions about actions to safeguard the child (and any siblings) but should also consider if the criteria for notification to National Panel is met. This consideration should be included in information in the Safeguarding Alert sent to the Safeguarding Unit.

When **serious harm** or **death** occurs and where abuse and neglect is known or suspected, the Local Authority must make the notification to the Panel within **5 working days** of knowledge of the incident. Notifications to the Panel are shared with Ofsted and DfE and support their oversight and monitoring of the work of the Local Authority.

When a child from another local authority, placed in Kent, suffers significant abuse or neglect and meets the criteria for a National Panel notification, the placing local authority will be invited to make a notification and confirm this within 24 hours. If this is not confirmed, Kent will make the notification.

In addition, the Local Authority must notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected.

**Notification of a Death of a Care Leaver -** From January 2024, local authorities should notify the Secretary of State for Education and Ofsted of the death of a care leaver aged up to their 25th birthday as per the revisions to Working Together to Safeguard Children 2023. By submitting a notification, the Local Authority will ensure that relevant learning from incidents is identified and fed back into the system to prevent future harm or death. The notification is for information purposes only and will not lead to a review of any type.

Referrals to KSCMP are made in two ways. Either a partner agency submits a referral via the KSCMP portal, or KCC Integrated Children's Services are notified of an incident and share with KSCMP. All referrals into the Partnership are discussed by senior representatives from the three statutory Safeguarding Partners (the Executive) to assess whether the case should be notified. If deemed to meet the threshold, the local authority is then responsible for submitting the National Panel notification.

When a district team/service completes a Safeguarding Alert where consideration for National Panel notification is highlighted, the information will be reviewed by the Safeguarding Unit. The Principal Social Worker (PSW) or one of his team will liaise with the district team to establish the criteria for notification. This may require further information to evidence harm and if attributable to the care provided. Due to the statutory timescales for notification to the National Panel, **it is vital that timely and detailed alerts are sent through the Need to Know/Safeguarding Alert form on Liberi**.

Once a notification is made to the National Panel, KSCMP must convene a **Rapid Review within 15 days of notification.** All agencies involved with the child or young person subject to the notification are required to complete an Agency Involvement Summary Report in preparation for the Rapid Review meeting. Practitioners/managers involved with the child may be contacted by our agency author to provide further information and share information as required.

The flowchart below indicates timescales of actions and the flowchart in appendix 5 shows the KSCMP process and timescales.

# Agency Involvement Summary Report

**Purpose**

The Agency Involvement Summary Report supports the Child Safeguarding Practice Review process. It enables ICS to demonstrate to statutory partners what may already be in place or how ICS is planning to address identified learning.

Understanding the impact of the actions taken by different organisations and agencies for the child and family, and whether different approaches or actions may have resulted in a different outcome, is essential to our collective learning. The Child Safeguarding Practice Review and by extension, the Agency Involvement Summary Report, should be viewed as a learning process.

# **Who undertakes the Agency Involvement Summary Report?**

The Agency Involvement Summary Report is undertaken by a member of the Safeguarding, Professional Standards and Quality Assurance unit (SPSQA).

The PSW will work closely with the author of the report to decide who will be spoken to as part of the completion of the Agency Involvement Summary Report. This will be on a child-by-child basis depending on the circumstances and services involved.

The PSW will liaise with the AD for the allocated service and advise on who will complete the agency summary and National Panel notification. The allocated team or service should be made aware by their AD/SM that an Agency Summary Involvement Report is being completed and a notification made to the National Panel and KSCMP. The well-being of staff should be considered by the service. Individuals/teams should be encouraged to ask for and access support if required. This may be within supervision, meeting or discussion, or part of an agreed check-in.

# Rapid Review

The Rapid Review meeting, attended by the Director of Children’s Services, enables safeguarding partners to gather the facts of the incident; determine the current situation for the child and their family: if immediate safeguarding action is required; share learning; consider potential practice recommendations; and decide whether to undertake a Local Child Safeguarding Practice Review (LCSPR) or recommend consideration of a national review to the Child Safeguarding Practice Review Panel (CSPRP). The Director of Children’s Services or representative will inform the PSW and relevant AD(s) so that the allocated team involved with the child are informed about the outcome of the Rapid Review

As part of the review process there may be learning actions identified within our agency and/or across the partnership. These requests are monitored by the KSCMP Learning Improvement Group and tracked by the PSW.

## Membership of the Rapid Review **-** Rapid reviews must be quorate and include the following members:

|  |  |
| --- | --- |
| Chair | KSCMP Business Team (Usually Practice Review Manager)  |
| Decision Makers | Director, Integrated Children’s Services, KCC Detective Superintendent/ Detective Chief Inspector, Protecting Vulnerable People Command, Kent Police Head of Adult and Child Safeguarding, Kent and Medway NHS ICB |
| Other | Up to two additional attendees (on a case-by-case basis) to provide information and guidance only. KSCMP Business Team – System Improvement Manager and Business Officer. |

These are the possible outcomes of the Rapid Review:

****

# Independent Management Review (IMR) reports

An IMR report is a more detailed review than an Agency Involvement Summary Report. The aim is to improve safeguarding practice by looking openly and critically at individual and organisational practice and the context within which people were working and to identify learning about how to improve safeguarding practice. It will require reviewing information about the child and writing a concise summary which includes critical analysis and identifying both individual and systemic learning by providing recommendations and SMART actions. An IMR Author will:

* Attend an author’s briefing meeting, which will include information on the process and what will happen next, and specific questions that need answering.
* Assemble all the facts and understanding how things were perceived at the time and the rationale for any decisions taken.
* Complete a thorough review of all the records e.g., Liberi, EHM, Youth Justice and Open Access (Core +) and completing a chronology.
* Identify and speak to relevant individual staff members.
* Take context and structural issues into account.
* Remain openminded.
* Undertake analysis and critical thinking.
* Complete a chronology.
* Write a report with key information and analysis from which recommendations and actions will improve safeguarding.

Following completion of the IMR, the next steps can vary as each review has a bespoke methodology. Generally, all the IMR’s will be circulated to all the IMR authors and Panel members. The IMR Author is invited to a Panel meeting to discuss the findings in their report with the other Panel members.

# Local Child Safeguarding Practice Reviews (LCSPR)

If the decision is to commission an LCSPR, the key lines of enquiry and the questions that are to be answered by the review process will be set out in the conclusion to the Rapid Review.

An independent author for the LCSPR will be appointed by KSCMP and a multi-agency Panel established where the Terms of Reference for the review will be agreed. An Independent Management Review (IMR) report will be requested from each agency by KSCMP to support the independent author compile the LCSPR. In ICS, the IMR author will be from the IMR agency author list. They will attend the authors’ briefing with the independent author, establish who needs to be seen and what information needs to be gathered as part of the Terms of Reference, and over what period. The PSW will share details of our agency IMR author with the relevant AD noting which staff may be approached as part of completion of the agency report. The area AD will inform staff of the LCSPR and ensure appropriate support is in place for the individual/team/service.

The PSW will provide supervision to the author and will oversee the completion and quality of the report. Our agency IMR will be approved by the Assistant Director of SPSQA.

There will be regular LCSPR Panel meetings, attended by the AD of SPSQA, where Panel members will review the agency reports, findings, draft reports by the independent author and to agree actions including how/when and if the report will be published. They should challenge any inaccurate information, judgemental/ inappropriate language, and any recommendations which are not appropriate or realistic.

The LCSPR may take several months to complete and publication is usually done in consultation with family members who are made aware of the review and can give their thoughts about what happened and contribute to the learning. The QA unit will feed back progress to the allocated service.

# Practitioner Events

On occasion, it may be appropriate to bring together practitioners from all the agencies involved with a family to consider learning. This could be to inform actions within a LCSPR or as a separate learning event to improve information sharing, understanding of each other’s roles and consider recommendations moving forward.

These events are organised by KSCMP and the relevant practitioners will be invited to attend and contribute to a reflective group discussion with the Independent Author. The practitioner and their Team Manager/Unit Lead must prioritise attending. Support for attending and contributing should be provided to the individuals by their respective AD/SM as the local authority’s expectation is that this is a mandatory event to contribute to the discussions and wider learning.

The PSW should be made aware of any issues arising from the practitioner event to escalate and support the district accordingly.

# Internal Reviews

An Internal Review may take place when the criteria for notification to National Panel has not been met but it is felt there is learning for a service, district, or the wider ICS.

The AD of SPSQA may authorise initiating an Internal Review following receipt of a Safeguarding Alert, but it may also be an action following a Rapid Review or Executive Meeting, for an individual agency to undertake their own internal review. In addition, this could be at the request of the DCS or district AD.

Recommendations may lead to training, practice guidance or policy change which would improve practice across Integrated Children’s Services.

# Child Death Process

There is a separate Child Death Process on Kent Procedures Online. Below is a brief overview of the process and Child Death Review, a term used to describe the formal process that happens after a child dies unexpectedly.

An unexpected death of a child is one which was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death (Working Together to Safeguarding Children, 2018).

The diagram below sets out the three stages of the overall process and the different parts that may take place:

Following the notification of an unexpected child death, an Immediate Decision-Making Discussion will be held within the Health Service (needing no involvement from Children’s Social Work Services at this time), which will decide whether a **Joint Agency Response (JAR)** should be triggered. This will be triggered if a child’s death:

* is or could be due to external causes
* is sudden and there is no immediate apparent cause including Sudden Unexpected Death in Infancy/childhood (SUDI/C)
* occurs in custody, or where the child was detained under the Mental Health Act
* where the initial circumstances raise any suspicions that the death may not have been natural
* in the case of a stillbirth where no healthcare professional was in attendance

Additionally, a JAR should be triggered if a child is brought to a hospital near death, and the child is successfully resuscitated, but is expected to die in the following days.

**The JAR should take place within 72 hours** after the unexpected death of a child and it is Chaired by a health representative, usually the Designated Doctor.

**What is the purpose of a JAR?**

The purpose of a Joint Agency Response meeting is to ensure that the appropriate agencies engage and work together to:

* Respond quickly to the unexpected death of a child.
* Make immediate enquiries into and evaluate the reasons for and circumstances of the death, in agreement with the coroner.
* Undertake enquiries/investigations that relate to the current responsibilities and actions of each organisation when a child dies unexpectedly. This includes liaising with those who have ongoing responsibilities for other family members.
* Collate information in a standard, nationally agreed manner.
* Work together appropriately post death, keeping contact with family members via an identified key worker to ensure that they are appropriately supported and informed of all information concerning their child.

The JAR should be attended by the relevant Service Manager (FDS if child not known to a service or Service Manager for the allocated team). The Service Manager should record the outcome and any actions from the JAR on the child’s file and complete an updating Need to Know/Safeguarding Alert form on Liberi.

**NB. The JAR is not a process to decide if a National Panel Notification should be completed. This is a decision made by the Corporate Director for CYPE. If significant concerns of abuse or neglect are raised at the JAR, a separate Strategy Discussion should be convened to consider the concerns and recommend actions, one of which may be to consider and recommend a notification to National Panel. An updating safeguarding alert should be completed to inform the Area AD and SPSQA.**

# Safeguarding Adult Reviews

A Safeguarding Adults Review (SAR) is a multi-agency review which seeks to determine what relevant agencies and individuals involved could have done differently, which could have prevented serious abuse or neglect or a death from taking place.

The Care Act 2014 states that Safeguarding Adult Boards (SAB’s) have a statutory duty to arrange a Safeguarding Adult Review (SAR) when:

* an adult in its area dies as a result of abuse or neglect, whether known or suspected, or
* the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect, and
* there is concern that partner agencies could have worked together more effectively to protect the adult from harm.

The purpose of a SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again. The objectives include establishing:

* lessons that can be learnt from how professionals and their agencies work together
* how effective the safeguarding procedures are
* learning and good practice
* how to improve local inter-agency practice
* service improvement or development needs for one or more service or agency.

When the SAB decides a review should be held, an independent author will be commissioned to bring together all the information from agencies. If the adult had children who were known to services, the relevant local authority may be asked to complete an Independent Management Report (IMR). There is a pool of authors who can called on to complete the IMR. The authors are social workers of Team Manager level or above. They must be independent of the adult/team/service. The process undertaken is the same as when an IMR is completed for an LSCPR.

The Service Manager for Safeguarding, Quality Assurance and Professional Standards offers supervision to the IMR author and oversight of the IMR.

# Domestic Homicide Reviews

Tragically, people sometimes die as a result of domestic abuse. When this happens, the law says that professionals involved in the case must conduct a multi-agency review of what happened so that we can identify what needs to be changed to reduce the risk of it happening again in the future.

The Kent Community Safety Partnership (CSP) oversee Domestic Homicide Reviews (DHR). If a domestic homicide or suspected domestic homicide takes place in Kent or Medway, Kent Police will make sure that the right people in the Community Safety Partnership are told as quickly as possible. After this initial notification, a decision will be made about whether we need to have a DHR using the Home Office guidance.

The purpose of a DHR is to:

1. establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.
2. identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
3. apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
4. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
5. contribute to a better understanding of the nature of domestic violence and abuse; and

 f) highlight good practice.

The narrative of each review should articulate the life through the eyes of the victim (and their children) and talking to those around the victim including family, friends, neighbours, community members and professionals. This will help reviewers to understand the victim’s reality; to identify any barriers the victim faced to reporting abuse and learning why any interventions did not work for them.

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate. DHRs are not specifically part of any disciplinary inquiry or process. Where information emerges during a DHR indicating that disciplinary action should be initiated, the established agency disciplinary procedures should be undertaken.

The decision on whether or not to proceed with a review should be taken by the chair of the CSP within **one month** of a homicide coming to their attention.

Agencies should also begin to work quickly to draw up a chronology of involvement with the victim, perpetrator and their families to help inform the terms of reference.

The overview report should be completed within a further **six months** of the date of the decision to proceed unless the review panel formally agrees an alternative timescale with the CSP. It is acknowledged that some DHRs will necessarily go beyond this further six-month timescale due to the complex scope of the DHR and/or due to on-going criminal justice proceedings. If the CSP believes that the delay to completion of the review is unreasonable, they should refer the issue to the Quality Assurance Panel for further advice.

There will be a representative from SPSQA who attends DHR panel meetings and disseminates any learning to services and ensures training, resources, policy and practice reflect learning from DHRs. Our agency author will be selected from the ICS IMR author list, attend the author’s briefing and complete the agency summary liaising with the ICS DHR panel member to agree the report.

The Service Manager for Safeguarding, Quality Assurance and Professional Standards offers supervision to the IMR author and oversight of the IMR.

# Guidance for the allocated practitioners, managers, and teams, where a safeguarding review is being completed on a child or their parent(s)

Practitioners and managers may be spoken to as part of the review as this will add context and depth of understanding to information. The expectation is that staff make themselves available and be open to sharing learning, be open to the enquiry, be reflective and discuss all the relevant information. This is not a formal interview.

For some advice for practitioners and managers see [appendix 3.](#_Appendix_3_-)

##

Where there has been a significant incident, some staff may need additional support to manage this. Staff can access Support Line individually or Amparo as a group. Group sessions should be considered and if appropriate arranged by the relevant Service Manager.

**Point of note for managers:**

Whilst this process is a learning process, there may be times when the accountable line manager with oversight considers policy, practice guidance and professional standards were not followed, and this warrants consideration regarding performance and capability or referral to Social Work England. This is a separate process and not within the remit of any of the above reports. Managers should access support with this process through HR Connect and the [**Performance and Capability Procedure**](https://kentcountycouncil.sharepoint.com/%3Aw%3A/r/sites/KCCKNet/_layouts/15/Doc.aspx?sourcedoc=%7BD206111B-73A8-432D-9891-3C8E29163DB3%7D&file=Performance%20and%20capability%20procedure.docx&action=default&mobileredirect=true&DefaultItemOpen=1) or through the Principal Social Worker regarding [**Social Work England Professional Standards**](https://www.socialworkengland.org.uk/standards/professional-standards-guidance/)**.**

#

# Appendix 1 – Glossary

|  |  |
| --- | --- |
| Rapid Review | A Rapid Review is a multiagency review of a child’s case that is carried out in response to a serious safeguarding incident. |
| Local Child Safeguarding Practice Review | It is for safeguarding partners to determine at the Rapid Review whether an LCSPR is appropriate. Good practice LCSPRs identify new learning that is not yet available in local safeguarding systems, or they tackle perennial problems that need further or perhaps different attention. An LCSPR does not automatically explore learning from a rapid review in more detail although partners may decide to initiate an LCSPR for this reason. |
| Child Safeguarding Practice Review Panel | The Panel was established under the Children and Social Work Act 2017 and operates under the relevant legislation and statutory guidance. The Panel has the power to commission reviews of serious child safeguarding incidents and to work with local safeguarding partners to improve learning and professional practice arising from such incidents. CSPR’s would only be commissioned in serious circumstances of sufficient complexity and national importance.  |
| Internal Review | An Internal Review is undertaken by a particular agency to review their own actions and practice, to determine any learning for their specific agency.  |
| Agency Involvement Summary Report | The report completed by each agency to inform the Rapid Review. |
| Independent Management Review | An in-depth review by each agency, written for an LCSPR. The aim of the Independent Management Review is to provide learning about how to improve safeguarding practice. The author will require reviewing all information and writing a concise summary which includes critical analysis and identifying systemic learning by providing recommendations and SMART actions. |
| Terms of Reference | The Terms of Reference will set out the role and purpose of the LCSPR, DHR or SAR; who is required to be part of the panel; the scope of the review; the timescales; and any other aspects of note. The TOR is set at the first panel meeting. |
| Learning and Improvement Group | The LIG ensures practice review learning is disseminated and embedded throughout the Partnership. Key agency representatives offer insight into how recommendations can be translated into action in a meaningful and achievable way for their organisation and commit to owning and following up implementation and measuring of impact. |
| KSCMP Executive Board | Brings together the three statutory safeguarding partners to lead children’s safeguarding and the promotion of child welfare in Kent. It ensures:* that the legal requirements of Working Together 2018 are met.
* that children are safeguarded and receive the support that they require in a timely and appropriate manner.
* that all agencies that contribute to safeguarding activity are clear on their responsibilities and receive the relevant training and information; and
* that the public have confidence in the ability of relevant professionals to keep children safe.
 |
| LCSPR, SAR or DHR Author | An independent person appointed to bring together agencies, review the reports, ask for additional information and write a report with recommendations. |
| Child Death Overview Panel | A CDOP is held when a child dies (excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law). The purpose is to determine whether a child’s death was preventable.  |
| Joint Agency Response | A multi-agency meeting, led by Health, to discuss an unexpected child death and to communicate, collaborate and share information. |

##

# Appendix 2 - Roles and responsibilities

|  |  |
| --- | --- |
| Corporate Director for CYPE | * Makes decision regarding national Panel notifications.
 |
| Director for Children’s Services (DCS) | * AttendsRapid Review Panels.
 |
| Assistant Director (AD) for Safeguarding, Professional Standards and Quality Assurance | * Makes the initial decision of whether to notify the DCS regarding an incident.
* Approve the final Agency Involvement Summary Report.
* Attends the Local Safeguarding Children Practice Reviews
* Attends Rapid Review Meetings in the absence of the Director of Countywide Children’s Services
 |
| Principal Social Worker | * Overall monitoring and review of the safeguarding process from initial Safeguarding Alert to practice improvement
* Liaises with the Safeguarding AD and completes the National Panel Notification.
* Liaises with the AD and SM of the service(s) involved to inform them of the notification and once a decision is made by the KSCMP or Child Safeguarding Practice Review Panel.
* Liaises with the Social Work Standards Officer completing the Agency Involvement Summary Report, or the author of the Independent Management Review, and will make the decision about who should be interviewed and how.
* Informs the Area AD of the name of the person completing the report and the Area AD is encouraged to share details with staff.
* Overall responsibility for the quality of all safeguarding review reports.
* Ensures actions and recommendations are actioned, monitored and reviewed and learning is disseminated to the appropriate service.
* Monitors themes and trends across safeguarding alerts and reviews to ensure practice improvement.
 |
| Service Managers for Safeguarding, Professional Standards and Quality Assurance | * Attend Domestic Homicide Reviews and Serious Safeguarding Reviews
* Deputise for the AD for SPSQA
* Ensures actions and recommendations are actioned, monitored and reviewed and learning is disseminated to the appropriate service.
* Monitors themes and trends across DHRs and SARs and ensures practice improvement across ICS and collaboration with Adult Services.
 |
| Author of Agency Involvement Summary Report | * Meets the PSW prior to decide the parameters to the report, how the report will be completed, and who will be spoken to.
* Is required to interview relevant workers involved with the child/family. This will be decided by the PSW.
* Completes the report within the expected timescale.
* Sends the report to the PSW no later than 48 hours prior to the deadline for quality assurance.
* Attends review meetings with the PSW.
 |
| Author of Independent Management Re | * Attending an author’s briefing meeting, which will include information on the process and what will happen next, and specific questions that need answering.
* Assembling all the facts of the case and understanding how things were perceived at the

time and the rationale for any decisions taken. * A thorough review of all the records e.g., Liberi, EHM, Youth Justice and Open Access (Core +) and completing a chronology.
* Identifying and speaking to relevant individual staff members.
* Taking context and structural issues into account.
* Remaining openminded. Undertaking analysis and critical thinking.
* Completing a chronology.
* Writing a report with key information and analysis from which recommendations and actions will improve safeguarding.
 |
| Allocated teams/managers/practitioners | * Send prompt safeguarding alerts to senior managers to inform them of any significant incidents.
* Respond to requests for information in a timely way with as much relevant information as possible.
* Meet with authors of reviews, as requested.
* Be open to the process and reflective about the work with the child, family or parent.
* Attend Practitioner Events and any meetings requested.
 |

# Appendix 3 - Advice for practitioners or managers where a safeguarding review is being completed on a child or their parent(s)

Please stay calm and try not to worry. This is a learning process and will inform practice not just for your team but the wider workforce in ICS.

Review the child’s file, your recording and any decisions made. Make sure everything is up to date. This does not mean adding information retrospectively, such as supervision or case notes, but making sure current key information is up to date, such as case summary, key professionals, received documents are uploaded.

Be open, honest, and as reflective as possible. Remember that any questions are designed to gain understanding and identify learning, not to apportion blame. Try to be open to the experience.

You may want to consider an Appreciative Inquiry with your team as you may be able to identify practice which should be changed immediately. Alternatively, you may want to wait until the report is completed.

The review will be kept confidential and any decision to share learning with your district should be made by your Assistant Director and Service Manager. The learning will form part of wider planning for your district or Integrated Children’s Services.

# Appendix 4 – Guidance for Authors of Agency Involvement Summary Reports, Internal Reviews and Independent Management Reviews

The PSW will support you through the process but here is some guidance.

Consider:

* What services have or have not been received by the family during the time frame outlined, and any pertinent information to this
* Any relevant history or context for the family
* What learning there may be to glean, and so where a Local Child Safeguarding Practice Review should be focused, if that is the route determined.

The report should include:

* biographic information of the child(ren)
* information regarding the family, background, identity and protected characteristics
* current situation, including safeguarding arrangements in place
* analysis and learning
* single-agency actions and recommendations which are SMART
* chronology

The format of the report:

* All reports are completed on the appropriate template
* The is a formal document and should be written as such with no acronyms, no contractions, no colloquial language
* The document will be quality assurance by the relevant senior manager within SPSQA

# Appendix 5 - Flowchart from referral to KSCMP

By Rapid Review Days 13-15

By Rapid Review Day 15

By Rapid Review Days 11-13

By Rapid Review Day 9

Rapid Review Day 1

By day 3

Day 1

By day 5

Referral received via the portal on the KSCMP website

Assistant Director Of Safeguarding, Professional Standards & Quality Assurance (Children’s Social Care) notified of a serious incident

Details of incident shared with KSCMP Executive

KSCMP Executive discuss case via phone/email/MS Teams with Partners. Decision regarding National Panel with a clear rationale recorded

Incident **does not** meet threshold for notification

Consider single agency learning and close to KSCMP

Incident **does** meet threshold for notification

LA to notify National Panel

KSCMP Business Unit to request agency summaries and set date for Rapid Review Group

Agency summaries returned and Collated Summaries circulated to Rapid Review Group

Rapid Review meeting

Rapid Review report, genogram and Action Plan/Learning Summary finalised by Chair.

KSCMP Business Unit submits outcome to National Panel