Swindon Safeguarding Partnership

Local Child Safeguarding Practice Reviews

A Framework and Practice Guidance for Swindon Safeguarding Partnership

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Contents

Who is the Guidance for?

This practice guidance should be read by local 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.

About this Guidance

This guidance provides Multi-Agency Safeguarding Arrangements across Swindon 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-2023*

1. Introduction and Context

Introduction

The Children and Social Work Act 2017 introduced a legal framework in respect of local safeguarding arrangements for children. Responsibility for how a system learns lessons from serious child safeguarding incidents rests at a national level with the Child Safeguarding Practice Review Panel (the National Panel) and at a local level with the three Delegated Safeguarding Partners (Integrated Care Boards, police and local authorities). Local areas 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 Swindon. This is a commitment to being an improving and learning system, determined to make best use of scarce and precious resources 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, 2023.* It also outlines responsibilities for key people at every stage of the process and includes template documents and letters.

The guidance and template documents should not, however, be seen as a prescriptive approach. Instead, partners 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 serious child safeguarding case reviews, at local and national level, is to identify improvements that can be made to safeguard and promote the welfare of children. Learning is relevant locally but has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.

Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations, or agencies to account, as there are other processes for that purpose, including employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings. These processes may be carried out alongside a review or at a later stage. Employers should consider whether any disciplinary action should be taken against practitioners whose conduct and/or practice falls below acceptable standards and should refer to their regulatory body as appropriate.

Definition of a Serious Child Safeguarding Case

Working Together to Safeguard Children 2023 defines serious child safeguarding cases as those in which:

- Abuse or neglect of a child is known or suspected
- 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. This is not an exhaustive list. When making decisions, judgement 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.

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

Duty on local authorities to notify incidents to the Child Safeguarding Practice Review Panel

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

(a) the child dies or is seriously harmed in the local authority's area

(b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England

The local authority should notify the panel of any incident that meets the above criteria via the Child Safeguarding Online Notification System. It should do so within five working days of becoming aware it has occurred. Though the responsibility to notify rests on the local authority, it is for all three safeguarding partners to agree which incidents should be notified in their local area. Where there is disagreement, the safeguarding partners should follow the local resolution processes.

Criteria for a Local 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
- is one the panel has considered and has concluded a local review may be more appropriate

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

- they have cause for concern about the actions of a single agency
- there has been no agency involvement, and this gives them cause for concern
- more than one local authority, police area or ICB is involved, including in cases where a family has moved around
- the case may raise issues related to safeguarding or promoting the welfare of children in institutional setting

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.)

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 Abuse Related Death 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.

Approach and Principles

Swindon Safeguarding Partnership have agreed each case will be examined individually to determine the most appropriate methodology to identify and maximise learning.

Local Child Safeguarding Practice Reviews will be conducted in line with good practice principles and informed by the Munro Report. This includes the advice outlined in *Working Together to Safeguard Children 2023* and its predecessor documents as well as the good practice principles described in the SCIE / NSPCC 'Quality Markers'[1].

Decisions on whether to undertake a review will be made transparently and the rationale shared with all relevant partners. If a review is then to be conducted family members will be informed of the rationale.

[1] 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.

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

Swindon's Practice Review Group is made up of representatives from the Safeguarding Partners, along with any relevant safeguarding experts from partner agencies. 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.[2]

[2] 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.

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. https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

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:

- 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 will refer the issue to the 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 Delegated 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 (**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 relevant Practice Review Group / Delegated 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 relevant designated single point of contact for the Safeguarding Partners of any serious incident that they think should be considered for a Child Safeguarding Practice Review, using the ***Appendix 2, CSPR Referral Form – Part 1***. The single point of contact should ensure that referral has executive level sign off. The Strategic Support Unit will receive the referral and quality assure this. If a serious incident notification has already been made by the local authority then the Rapid Review process is triggered.

If it has not yet been determined whether a serious incident notification needs to be made, a three statutory partner meeting will be arranged within three working days to triage the referral.

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.

Where a local authority makes a formal notification to the National Panel or Ofsted, it must always share this with the relevant local Safeguarding Partners.

Rapid Review

When considering whether to conduct a Local Child Safeguarding Practice Review, Safeguarding Partners need to be clear from the outset what the added value is to a good rapid review. Rapid reviews should always set out a very clear rationale for doing a Local Child Safeguarding Practice Review they should be explicit about the key questions that the Local Child Safeguarding Practice Review would seek to answer. 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. 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 agencies who have been involved 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 will need to be rapidly gathered. To support this, ***Appendix 3, CSPR Rapid Review Information Gathering Form – Part 2*** should be completed by partners.

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 progress to a formal Child Safeguarding Practice Review.

The ***CSPR Rapid Review Information Gathering Form*** should be sent out to all relevant agencies **within 2 working days** of receiving the referral.

Agencies should prioritise completion of the form and return it **within 5 working days.**

All agencies should also secure all records/files in relation to the case, ensuring they are removed to a secure place where they are not accessible to agency personnel other than through a nominated representative. Where access to the records is required for ongoing casework, a copy should be made and secured.

Setting the Date of the Rapid Review Meeting

The date of the Rapid Review meeting should be set as soon as the ***CSPR Rapid Review Information Gathering Form*** have been sent out. The Strategic Support Unit will convene a Rapid Review meeting by day ten.

This will allow for analysis of the initial scoping and information sharing to establish the key events in the child's life and inform the Rapid Review whilst also allowing sufficient time to prepare the necessary documents for the National Panel.

Documentation

The following documents should be shared with all those attending the Rapid Review meeting:

- the completed ***CSPR Referral Form*** that initiated the process;
- the Local Authority Serious Incident Notification to Ofsted, the Department for Education and the National Panel in relation to the incident (if completed);
- Copies of the completed ***CSPR Rapid Review Information Gathering Form*** templates from relevant agencies.

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 meeting should include representatives from each of the statutory Safeguarding Partners (the ICB, police and local authority) and any other relevant individuals. It will only be quorate if **at least one representative is present from each of the statutory Safeguarding Partners** and this must be recorded in the Rapid Review documentation. If the meeting is not quorate, it cannot go ahead.

The Rapid Review meeting should:

- Review the facts about the case as presented in the documentation;
- Discuss whether any immediate action is needed to ensure children's safety;
- Identify immediate learning for individual organisations or multi-agency working that can be acted upon and agree how this will be shared. (This may remove the need for further review).
- Consider the potential for identifying improvements to safeguard and promote the welfare of children; and,
- Decide whether to undertake a Local Child Safeguarding Practice Review.

A thorough Rapid Review may mean that there is no need for a further meeting to conclude the Local Safeguarding Practice Review and areas can move quickly to implement learning across the system. Such a review should feature:

- A concise statement of what has happened;
- The key questions which emerge from an appraisal of the case;
- A detailed and sufficient analysis which addresses those key lines of enquiry; and,
- Clearly related learning with actions to address any weaknesses.

The analysis and outcome of the meeting should be recorded on ***Appendix 4, Rapid Review Template*** and should be shared and agreed by those attending the Rapid Review meeting. The Rapid Review report will be written by the Strategic Support Unit Manager or Strategic Support Unit Children's Lead.

There should be a clear process of quality assurance and for the ratification of the outcome of the Rapid Review by the Safeguarding Partners prior to submission to the National Panel. Partnership Practice Review Group will sign off the outcome of review, this would then be submitted to Delegated Safeguarding Partners to endorse the review.

Sharing the Outcome of the Rapid Review

By day 15, the Safeguarding Partners should send the completed Rapid Review report to the National Panel (Mailbox.NationalReviewPanel@education.gov.uk) together with a covering letter.

Other agencies (including the agency who made the referral) should also be informed of the outcome of the Rapid Review. Individual agencies should notify their own inspectorate bodies as required.

It is the responsibility of individual agencies to ensure that any learning identified in the review is implemented in a SMART way. If a Local Child Safeguarding Practice Review is going to be undertaken, there is the expectation that the Practice Review Group will continue to meet on a regular basis to review progress of the identified learning.

Practice Review Group Rapid Review – Business Process Flowchart

Day 1

Strategic Support Unit receives:
A. LCSPR case for Consideration Request or
B. Significant Incident Notification and/or
C. Letter from Child Safeguarding Practice Review Panel

1. SSP Delegated Safeguarding Partners and Statutory Partner Leads notified
2. Three Statutory Partner meeting arranged, if required
3. Rapid Review information gathering template prepared for circulation
4. Rapid Review timeline agreed with Strategic Partnership Manager

Day 2 & 3

1. Part 2 form & covering email circulated
2. Rapid Review Panel notified of panel meeting and provided with copy of Rapid Review timeline

Day 7

1. Information for Review Panel collated from agency information gathering templates
2. Final chase for any outstanding information gathering templates
3. Information for Review Panel distributed to panel members

By Day 10

1. Rapid Review Panel meeting held
2. Report is completed and agreed by Review Panel
3. Outline of ToR drafted (if required)

By Day 11

1. Rapid Review Panel recommendation sent to Delegated Safeguarding Partners to endorse, along with:

   A. Rapid Review report
   B. Outline ToR (if LCSPR recommended)

By Day 15

1. Rapid Review report sent to National Panel

Agreeing the Scope and Terms of Reference for LCSPR

The Practice Review Group will formally agree the scope and ***Appendix 5, Terms of Reference (ToR)*** for the review. The ToR will build on the learning identified in the Rapid Review and will need to consider the following:

Time Period

The period covered by the review should reflect the potential learning likely to be achieved. It should therefore, be as short and as recent as possible. ***Appendix 6, Timeline Template*** will be completed with the agreed timescales for each stage of the review. A timetable for the review will be agreed at the outset. This will include the timing of panel meetings, learning events and engagement with families.

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 ToR. These may, however, be revised as more information becomes available. Any significant changes should be formally approved by the Practice Review Group.

Methodology

As set above, the Safeguarding Partners are responsible for determining whether a review will take place and the methodology used. Each case will be examined individually and the methodology may be adapted to meet the specific needs of the case.

The ToR 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.

Engaging Children and Family Members

Using the information available, and the genogram where available (see Section 7), 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[3]. It is anticipated that a Local Child Safeguarding Practice Review will go ahead unless there are clear reasons not to.

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

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 https://www.cps.gov.uk/publication/protocol-liaison-and-information-exchange-when-criminal-proceedings-coincide-child

Legal Advice

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

5. Appointing the Lead Reviewer and Review Team

The Lead Reviewer

A Lead Reviewer will usually be appointed to manage the review process, chair meetings of the Review Panel facilitate the learning events and author the final report.

The Review Panel

For complex reviews, a small, multi-agency review panel 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 Panel will support the Lead Reviewer to scrutinise the information provided by agencies. The Review Panel 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.

6. Engaging Children and Family Members

Approach and Principles

Working Together to Safeguard Children 2023, 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[4] consideration will be given to how family members can be supported to engage. This may include interpretation and translation support if English is not a first language, additional support for disabled parents, specialist support where there are issues of domestic abuse, and drawing on expertise to facilitate the appropriate involvement of children.

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

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

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 Panel meetings 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 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 leaflet to explain and introduce the review process and Lead Reviewer. See ***Appendix 7, Letter to Family Members*** and ***Appendix 8, Sample Leaflet on Child Safeguarding Practice Reviews.***

Conversations with Family Members

Family engagement will be via the named contact so that the family's views can be included in the review. Where a Lead Reviewer is not commissioned, a nominated individual will be responsible for liaising with the family. However, engagement may not be possible until the outcome of any criminal proceedings.

7. Methodology

The 'Systems Methodology' and Expectations of Agencies

Working Together to Safeguard Children 2023, does not specify the methodology that should be used in Local Child Safeguarding Practice Reviews.

The Safeguarding Partners should agree with the reviewer the method by which the review should be conducted, taking into account this guidance and the principles of the systems methodology recommended by the Munro review[5]. It should provide a way of looking at and analysing frontline practice as well as organisational structures and learning, and allow those involved in the review to reach recommendations that will improve outcomes for children. All reviews should reflect both the child's perspective and the family context.

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.

[5] Munro review of child protection: a child-centred system - GOV.UK

Agency Action and Expectations

All agencies that provided services to the family during the time period specified in the ToR 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 way and practitioners are released to participate in the review. Agencies should also provide support to their staff who are affected by the case where required.

Information Collection and Collation

Where required, information will be collected through the use of a chronology template and part 2's. The ToR 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. ***Appendix 9, Template Email Request to Complete a Chronology*** and ***Appendix 10, Guidance on Completing Chronology Guidance*** will provide guidance on completing this.

Individual agency chronologies will be collated to produce a composite chronology. Once received composite chronology will be sent to Lead Reviewer.

Review Panel Quality Assurance of Agency Submissions

The work of the Review Panel, chaired by the Lead Reviewer, begins once initial information has been gathered. The Review Panel 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 Panel 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 part 2's, the Review Panel 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 ToR. 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 that 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 any reflective practitioner events.

Reflective Practitioner Session

Reflective practitioner sessions 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 Panel to identify important multi-agency learning.

Preparing for the Practitioner Session

The Review Panel will need to ensure it has a full list of appropriate professionals to invite to the Practitioner Session.

To maximise learning all agencies are expected to ensure that appropriate staff attend the session. However, it is preferable that only those who have been involved with the child and family attend.

Appendix 11, Template Email to Reflective Practitioner Session 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. ***Appendix 12, Briefing on the Reflective Practitioner Session.***

The Structure of the Practitioner Session

Reflective practitioner sessions may be held 'face to face' or virtually. Where a 'face to face' meeting is held, the reflective practitioner session will normally be undertaken over half a day, although a more complex case may require an additional half day. ***See Appendix 13, Agenda Template for Reflective Practitioner Session***.

The Lead Reviewer will normally facilitate the reflective practitioner session, supported by members of the Review Panel.

The structure of the session 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;
- 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.

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 practitioner session, 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 practitioner session.

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.

8. 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.

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

- A brief overview of what happened, 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 Panel will be responsible for ensuring the draft report has met the agreed terms of reference, is succinct and focused on improving local safeguarding arrangements.

The final report should be formally signed off at Practice Review Group and endorsed at Executive Group.

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 findings that will form part of the final report. In some instances, the Lead Reviewer and Review Panel may develop the findings. The Review Panel 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 the findings 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 at Executive Group.

9. 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 or equivalent) consider it inappropriate to do so.[6]

Preparing for Publication

Communications will be informed of any reviews that have been instigated and the relevant periods for publication. Publication planning will include strategic leads from the agencies involved in the review and their media/communication leads. A nominated communications lead will have been identified for each of the three statutory partners to lead on the publication.

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.

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

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:

- 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 Swindon Safeguarding Partnership Website. Reports will be publically available for **at least one year** and archived reports will be available on request.

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

10. 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 Panel 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[7]. 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 Panel 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 Practice Review Group and Learning and Development Group will be responsible for ensuring the identified improvements are implemented locally, including the way in which organisations and agencies work together.

[7] This ensures compliance with *Working Together 2023,* 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.'*

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, or producing briefing notes on the lessons learned for use in agency team meetings and/or supervision sessions.

It is the responsibility of the agencies who have participated in the review to ensure their agency recommendations are acted on.

Monitoring Progress

The Practice Review Group will regularly receive progress updates on the implementation of recommended improvements/actions and will regularly monitor and follow up actions to ensure improvement is sustained.

Taking into Account Learning from National Reviews

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

11. Appendices

Appendix 1:

Overview of Different Types of Learning Reviews

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

Domestic Abuse Related Death Reviews (DARDRs)

Domestic Abuse Related Death Reviews (DARDRs) were formerly called Domestic Homicide Reviews (DHR). They changed to DARDR to better recognise deaths from domestic abuse related suspected suicides.

Domestic Abuse Related Death Reviews (DARDRs) were established on a statutory basis under section 9 of the **Domestic Violence, Crime and Victims Act 2004 (DVCA 2004)** and came into force on 13 April 2011.

A DARDR is a locally conducted 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 he or she was related, or with whom he or she was or had been in an intimate personal relationship; or
- a member of the same household as himself or herself
-

This includes where a victim took their own life (suicide) and the circumstances give rise to concern, for example, it emerges that there was coercive controlling behaviour in the relationship.
Overall responsibility for establishing a review rests with the local Community Safety Partnership (CSPs), as they are ideally placed to initiate a DARDR and review panel due to their multi-agency design and locations across England and Wales.
CSPs are made up of representatives from the 'responsible authorities' (police, local authorities, fire and rescue authorities, probation service and health) who work together to protect their local communities from crime and help people feel safer.
Their purpose is not to reinvestigate the death or apportion blame, but to:

- 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
- identify clearly what those lessons are, both within and between agencies, how they will be acted on, within what timescales, and what is expected to change as a result
- apply these lessons to service responses including changes to policies and procedures as appropriate
- prevent domestic abuse homicide and improve service responses for all domestic abuse victims and their children, through improved intra and inter-agency working

The DARDR will usually draw upon information obtained from:

- interviewing family members
- interviewing significant people who may have known the victim
- obtaining information from participating agencies, either by way of an Individual Management Review (IMR), or by other means such as a chronology of events

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.

Appendix 2:

Consideration of Case for Review by Swindon Safeguarding Partnership

Part 1

"The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children." (Working Together to Safeguard Children 2023)

This referral form is to be used to request that the Safeguarding Partnership consider whether a serious incident notification may need to be made to the National Child Safeguarding Practice Review Panel, triggering the rapid review and case review process.

In some cases, a 'serious child safeguarding case' may not meet the criteria for a serious incident notification but may raise issues of importance to the local area. That might, for example, include where there has been good practice, poor practice or where there have been 'near-miss' incidents. Safeguarding partners may choose to undertake a local child safeguarding practice review in these or other circumstances, in which case they should be clear about their rationale for undertaking such a review and what its focus will be (Working Together to Safeguard Children 2023).

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

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

(a) the child dies or is seriously harmed in the local authority's area

(b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England

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. This is not an exhaustive list. When making decisions, judgement 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

Please let us have as much information as is readily available at the time of the referral. If information is unavailable, do not delay in making the referral. Additional facts can be considered later on.

Please return completed forms safeguardingpartnership@swindon.gov.uk

Section 1:	
1.1 Referral Details	
Date of notification to SSP	
Name of referrer	
Agency	
Address	
Tel No.	
E-mail	

1.2 Child's Details					
Child's First Name:					
Child's Surname:					
Any Know Aliases:					
Date of birth: *(DD/MM/YYYY)*					
Date of death *(if applicable):* *(DD/MM/YYYY)*					
Address:					
Gender:		Male		Female	
Ethnic origin – please tick the relevant box					
(A) White		(B) Mixed		(C) Asian or Asian Britain	
	British		Asian and White		Indian
	Irish		Black African and White		Pakistani
	Any other White background		Black Caribbean and White		Bangladeshi
			Any other mixed background		Chinese

					Any other Asian background
(D) Black or Black British		(E) Other Ethnic Group		(F) Not declared	
	Caribbean		Please specify		Not declared
	African				
	Any other Black background				
Faith:					
Disability:					
Location of incident:					
Carer at time of incident:					
First Language:					

1.3 Family composition/significant others

Name	Relationship to child	DOB	Address	Legal status and/or current criminal proceedings	Ethnic origin	Is/was subject to a CP plan? Specify category of plan.

1.4. Agencies known to be involved with the case (please add their name and contact details)

Name	Agency	Contact details	Are they still involved?

1.5. Reason for notification (more than one box may be ticked) **Please add comment specifying why this is a serious case and of local significance in terms of practice improvement.**	
When a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the death	
A child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard children	
A child who is cared for by the local authority has died (including cases where abuse or neglect is not known or suspected)	
A child in a regulated setting* or service has died (including cases where abuse or neglect is not known or suspected) *(* A regulated setting or service: childcare on domestic premises or non-domestic premises; home child carer; childminder; children's homes; secure children's homes; adoption support agencies; voluntary adoption agencies; independent fostering agencies; residential family centres and holiday schemes for disabled children)*	
A child has died in police custody, or remand or following sentencing, in a Young Offenders Institution, in a secure training centre or a secure children's home	
A child has died who was detained under the Mental Health Act 1983 or where a child was the subject of a deprivation of liberty order under the Mental Capacity Act 2005	
There was clear evidence of a risk of significant harm to a child that was: • not recognised by organisations or individuals in contact with the child or perpetrator or • not shared with others or not acted on appropriately	
The case indicates that there may be failings in one or more aspects of the local operation of formal safeguarding children procedures, which go beyond the handling of the specific case. For example, the case suggests that the Safeguarding Partnership may need to change its local protocols or procedures, or that protocols and procedures are not being adequately implemented, understood or acted on, or there are thematic concerns.	
The child concerned was the subject of a child protection plan, or had previously been the subject of a plan or on the child protection register	
There are indications that the circumstances of the case may have national implications for systems or processes or there are significant public interest or community issues.	
Other reason *(please specify)*:	

1.6 Characteristics of Case					
Domestic abuse		Alcohol abuse		Drug abuse	
Parental mental health		Fabricated illness		Shaken baby syndrome	
Sexual abuse		Parent in care		More than one child abused	
Child of teenage pregnancy		Parent is care leaver		Serious illness	
Emotional abuse		Recent neglect		Long standing neglect	
Physical abuse		Other features (please specify)			

Is the child subject to :	Yes		No		Has been		Don't know
Child Protection Plan?							
CIN							
TAC							
LAC							

Are any siblings subject to a child protection plan?	Yes	No	Has been	Don't know
Have criminal proceedings been instigated?	Yes	No		Don't know
Has there been a conviction?	Yes	No		Don't know

1.7 Summary of events
Please outline events and circumstances, which triggered this referral. Please refer to Chapter 5 of Working_together_to_safeguard_children_2023 this is to help establish if the case meets the serious incident notification criteria and does not need to be detailed analysis of involvement at this stage.

Why you think this meets the criteria for a case review and reason for concern? *Please include your reflection on how partners worked together.*
What worked well?
What are you worried about?
What you think are some of the key issues and what you think needs looking at in the review?
Is there any additional information you think may be relevant and assist decision making?

Signature:	
Date:	

Please return completed forms: safeguardingpartnership@swindon.gov.uk

There is further guidance from Working together to safeguard children 2023, chapter 5, in relation to criteria for a child safeguarding practice reviews.

When a serious incident becomes known to safeguarding partners, they must consider whether the case meets the criteria and guidance for a local review. If safeguarding partners determine that the criteria is met to undertake a local child safeguarding practice review, then a serious incident notification and rapid review must take place.

In some cases, a 'serious child safeguarding case' may not meet the criteria for a serious incident notification but may raise issues of importance to the local area. That might, for example, include where there has been good practice, poor practice or where there have been 'near-miss' incidents. Safeguarding partners may choose to undertake a local child safeguarding practice review in these or other circumstances, in which case they should be clear about their rationale for undertaking such a review and what its focus will be.

It is for safeguarding partners to determine whether a review is appropriate, given that the purpose of a review is to identify improvements to practice. Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review.

All incidents should be considered on a case-by-case basis using all information that is available to local safeguarding arrangements. Issues might appear to be the same in some cases, but reasons for actions and behaviours may differ resulting in useful learning for the local area.

Decisions on whether to undertake reviews should be made transparently and collaboratively between safeguarding partners, and the rationale recorded and communicated appropriately, including to families. Where there are disagreements, local dispute resolution processes should be followed.

Safeguarding partners must consider the criteria and guidance below when determining whether to carry out local child safeguarding practice review.

The criteria which the local safeguarding partners must take into account include whether the case:
• highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified • highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children • highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children • is one the panel has considered and has concluded a local review may be more appropriate

Safeguarding partners should also have regard to the following circumstances:
• they have cause for concern about the actions of a single agency • there has been no agency involvement, and this gives them cause for concern • more than one local authority, police area or ICB is involved, including in cases where a family has moved around • the case may raise issues related to safeguarding or promoting the welfare of children in institutional settings

Top Tips for Referrers

Any agency can refer a case to the Safeguarding Partnership requesting that consideration be given to whether a case should meets the criteria for a serious incident notification to the National Panel therefore triggering the case review process. Cases can also be referred by the Coroner, or Child Death Overview Panel.

Single agency agreement: Where an agency has identified a possible referral, the case should first be considered internally within the organisation at the appropriate level, but with due consideration to timescales. For some cases, such as child deaths, it will be obvious that a referral is required. Each organisation needs to decide how a referral will be verified internally before the referral is made to the Safeguarding Partnership. This process should be clearly communicated and noted in the child record within that agency.

Consult key workers: There is an expectation that the referrer would have a conversation with any allocated social worker or other key worker to alert them to the intention to refer and gather their views. Be clear that the right way to progress is through referral, and not via the resolution process.

Discuss with child /family as appropriate: It is good practice to involve parents and children (subject to age and understanding) in a meaningful way. Reviews should, where appropriate, be informed by family members' knowledge and experiences relevant to the period under review. Please provide your views on how children and their families should be involved, and who should be responsible for facilitating their involvement, recognising that not all information should be shared with the child or family.

The overarching principle should always be to act in the best interests of the child. If it is decided that such involvement is not in the best interests of the child then the reasons for the decision should be clearly stated in the referral.

Completing the form: Please complete Part 1. Whilst we recognise the referrer may not know all the information, please provide as much information that is known at the time of the referral. If information is not available, please do not delay in sending the notification, as this information can be submitted at a later stage.

Appendix 3

Swindon Safeguarding Partnership
CSPR Consideration/Rapid Review
Part 2 - Information Gathering

This form is to request information from agencies when a serious incident notification has been made to the National Child Safeguarding Practice Review Panel and where this has triggered the Rapid Review process and consideration of a CSPR.

"The purpose of serious child safeguarding case reviews, at local and national level, is to identify improvements that can be made to safeguard and promote the welfare of children. Learning is relevant locally but has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving" (Working Together to Safeguarding Children, 2023)

The role of the Practice Review Group and review panel is to coordinate Rapid Reviews and consider referrals for child safeguarding practice reviews on behalf of the statutory partners. Some cases may not meet the definition of a 'serious child safeguarding case', but nevertheless raise issues of importance to the local area.

Definition of a serious child safeguarding case

Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected
- 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. This is not an exhaustive list. When making decisions, judgement 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.

Please let us have as much information that is readily available at the time of the request. If information is unavailable, do not delay in making the response. Additional facts can be made available later.

Please return completed forms safeguardingpartnership@swindon.gov.uk

Details of child			
Child's First Name:			
Child's Surname:			
Any Know Aliases:			
Date of birth:			
Date of death:			
Address:			
Gender:		**Ethnicity:**	

Your details			
Name		**Agency**	
Address		**Tel No:**	
Email			
Date			
Signed			

Organisational involvement
Please provide any relevant background information from dates: on your organisation's involvement with the child/family. Please provide any information prior to this date if you feel it is relevant.
(please continue on a separate sheet if necessary)

Swindon Safeguarding Partnership

January 2022

Analysis & Reflections

Please provide analysis/reflections on your organisation's involvement with the child/ren and their family, carers or relatives. Please consider the following:

Areas of strength shown by your agency when working with this family:	
Areas for improvement / potential learning for your agency when working to keep this child/ren safe:	
Any key areas of learning and actions that you would now recommend for your agency:	
Any key area of learning and actions that you would recommend for partner agencies?	
Child's voice: Is it recorded if so, what does it tell you?	
Were colleagues curious about the family's past history & current circumstances in a way that was beyond reliance on self-reported information?	
Information sharing: was it timely and effective?	
The impact of culture, race and ethnicity:	
Any further comments?	
(Please continue on a separate sheet if necessary)	

Appendix 4

Rapid Review Template

Purpose of the Rapid Review	
In line with *Working Together to Safeguard Children 2023*, the aim of this Rapid Review is to enable Safeguarding Partners to: • Gather the facts about the case, as far as can be readily established; • Discuss whether any immediate action is 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 what steps to take next, including whether or not to undertake a Local Child Safeguarding Practice Review or whether to recommend at National Child Safeguarding Practice Review.	
Agency who notified the Safeguarding Partnership	
Date of three Statutory Partner meeting	
Date of notification to the National Panel	

1. Details of Child, Family Members and Significant Others

Name of Child	
Date of Birth	
Sex	
Ethnic Origin	
Address	
Date of Rapid Review	

Name and Address	Relationship to Child	Date of Birth	Legal Status	Ethnic Origin

2. List of Participants in Rapid Review:		
Name	**Job Role/Title**	**Agency/Organisation**

3. Summary of Serious Incident – Please provide a brief outline of the child/children and family circumstances and the serious incident that triggered this Rapid Review:

4. Consideration of Case, Criteria and Guidance
Has any immediate action been taken to ensure child and siblings (if relevant) are safe? If yes, please give details and how this will be acted on. If no, what actions need to be taken? When will these actioned and by whom?
Has any immediate learning been identified? If yes, please give details and how this will be acted on and by whom?
Has legal advice been sought?

5. Record of Rapid Review discussion: • This should include relevant background information on the family, all of the children not just the one(s) harmed or who died. • The discussion should focus on reflection and analysis of the information collated. • This should also include a brief explanation of the Rapid Review's conclusion on the nature of the harm the child/ren have suffered, and how it meets the criteria for a Child Safeguarding Practice Review.

6. Local Decision Those present at the Rapid Review have reviewed the information from the Rapid Review and considered the following questions from *'Working together 2018'* and have agreed that the case has the potential to meet the following criteria:		
Highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.	**YES**	**NO**
Highlights or may highlight recurrent **themes** in the safeguarding and promotion of the welfare of children.	**YES**	**NO**
Highlights or may highlight concerns regarding **two or more** organisations or agencies working together effectively to safeguard and promote the welfare of children.	**YES**	**NO**
The case is one, which the Child Safeguarding Practice Review Panel has considered and concluded a local review may be more appropriate.	**YES**	**NO**
Safeguarding Partners have cause for concern about the actions of a **single** agency.	**YES**	**NO**
There has been **no agency** involvement and this gives the safeguarding partners cause for concern.	**YES**	**NO**
More than one local authority, police area or ICB is involved, including in cases where families have moved around.	**YES**	**NO**
The case may raise issues relating to safeguarding or promoting the welfare of children in **institutional settings**	**YES**	**NO**
None of the above	**YES**	**NO**

7. Recommendation After completing this Rapid Review it has been agreed that this case:			
A) Meets the criteria for a national Child Safeguarding Practice Review	**YES**	**NO**	
B) Meets the criteria for a Local Child Safeguarding Practice Review	**YES**	**NO**	
C) Does not meet the criteria but warrants an alternative Learning Review	**YES**	**NO**	**OTHER – PLEASE STATE**
D) Warrants consideration of DHR, SAR, MAPPA SFO or other	**YES**	**NO**	**OTHER – PLEASE STATE**
E) Warrants a Single-Agency Review	**YES**	**NO**	
F) Warrants a Multi-Agency Audit	**YES**	**NO**	
G) Warrants a Single Agency Audit	**YES**	**NO**	
H) Needs no Further Action	**YES**	**NO**	
I) Other, Please state:			

Rationale for Recommendations: What are the next steps going to be and why?

8. Good Practice Identified	
Agency	**Evidence of Good Practice**

9. Learning & Actions Identified		
Agency	**Learning & Recommendations**	**Actions**

The Rapid Review does not recommend any specific points to the National Panel for their consideration within wider review frameworks – REMOVE IF NOT NEEDED

Actions from the Rapid Review will be progressed and monitored via Swindon Safeguarding Partnership's Practice Review Group. Learning identified will be disseminated across the partnership via Practice Review Group members who represent the partner agencies involved in the review.

Date this form submitted to the National Panel:	

Appendix 5: Terms of Reference Template

Terms of Reference for a Child Safeguarding Practice Review

Overview

Purpose and Principles

Process

Methodology

Lead Reviewer

Key Lines of Enquiry

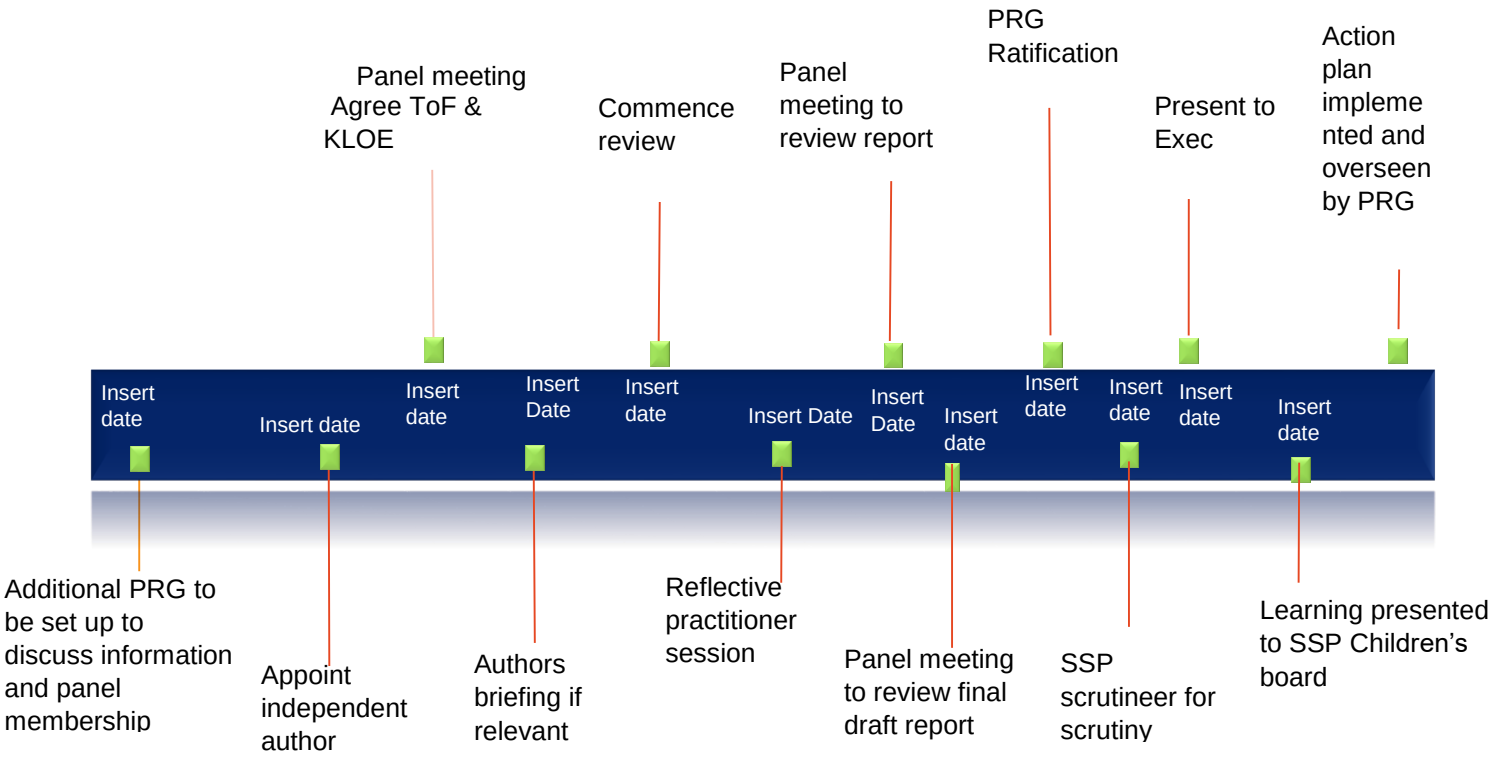
Timeframe for review

Family involvement in the review

Relevant Agencies

Anticipated timing of key steps in the Review process

Appendix 6: Example LCSPR Timeline Template



Appendix 7: Template Letter – Informing Family Members of a Review

Date: [insert date]

Dear [insert name],

RE: Subject (?)

Firstly, I would like to say how sorry I am about the tragic death / serious injury of your daughter / son / brother / sister / granddaughter / grandson, [insert child's name]. I understand this must be a very difficult time for you and your family.

I would like to introduce myself and explain why I am writing to you. My name is [insert name] and I have been asked to lead an independent review to look at the way in which agencies and services worked with your family in the time before [insert name] died / suffered [insert serious injury].

The review is officially called a 'local Child Safeguarding Practice Review'. The purpose is to consider how organisations (such as police, health, schools and the local council) worked together and whether there are improvements that could be made to prevent, or reduce the risk, of similar incidents happening in the future. I enclose a leaflet, which explains more about these reviews.

This review is completely separate to any investigation into how [name] was [seriously injured / sadly died] that may be taking place. When I am able, I would like to visit you to hear about the services you received. We believe it is very important that family members share their experience, including the quality of services and whether anything could have been done better.

If you are willing to help us learn from this, please contact [insert name] on [insert telephone number] so that a meeting can be arranged. If you have any questions or concerns please contact [insert name] on [insert telephone number].

Yours sincerely,

[Insert name], Independent Lead Reviewer

Appendix 8: Sample Leaflet for Families

The Independent Lead Reviewer for your case is:

If you have any questions or want to know more contact:

Insert here contact details of the person who will be able to answer questions and queries

Child Safeguarding Practice Reviews

Information for Parents and Carers

Swindon Safeguarding Partnership

What is a Child Safeguarding Practice Review?

The Police, Health, Council and other agencies are required to work together to keep children safe. When things go wrong (such as when a child or young person has been seriously harmed or has died as a result of possible abuse or neglect) they are required to take action to prevent similar deaths or injuries happening in the future.

To do this they usually undertake a Child Safeguarding Practice Review. This looks at how organisations worked together to provide services to the child or young person who is the focus of the review, and to their family.
The purpose of the review is to:

- establish whether there are any lessons that can be learned by professionals and organisations;
- identify who those lessons are for; and
- plan how the lessons will be acted upon.

A Safeguarding Practice Review is not an investigation into how a child died or was seriously harmed. It is also completely separate from any investigation by the Police or the Coroner.

Who will carry out the Safeguarding Practice Review?

An independent Lead Reviewer has been appointed to oversee the review and produce a report that will be published. The Lead Reviewer will be supported by senior managers from organisations such as health, police, and the Council.

All the organisations who have worked with your child or family will be asked to provide information. Analysis of this information will be included in the final report.

Practitioners and managers involved in the case will also be invited to a meeting to share information and help identify how to improve services and support for children and families in the future.

How are parents and families involved?

We believe it is very important that family members share their experience of services and tell us whether anything could have been done differently. You are, therefore, invited to meet the Lead Reviewer to discuss any concerns you have about the services you received and to share any things that you feel helped you or your family.

When the review is complete, we will arrange to meet with you to share the learning and to provide you with a copy of the final Report.

If you want to know about any changes that come from the review, you should talk to your contact about how you can hear about these and who can keep you informed of progress.

How long will the review take?

All local child safeguarding practice reviews should normally be completed within six months of the decision being taken to start the review. Sometimes this timescale may be extended, but you will be kept informed if this needs to happen.

Publication of the report

The report will not contain any identifying details of your child or family. It will then be published on the Swindon Safeguarding Partnership website and the NSPCC Website.

The report will be available to all Professionals to ensure that the lessons learned and recommendations made are put into practice.

Appendix 9: Template email Request to Complete a Chronology

Date: [insert date]

Dear add in name

Request to Complete Chronologies for a Safeguarding Review

We are undertaking a local Child Safeguarding Practice Review into the tragic death / serious injury of [insert name of child (ren)]. The first stage of the review process is for each agency to complete:

- a chronology of their agency's involvement with the child and/or their family members; and
- a chronology of organisational changes that may have impacted on frontline practice.

I would, therefore, appreciate it if you could arrange for completion of these two documents.

To support completion, I attach two additional reference documents:

Guidance Notes on the type of information that should be included in the chronologies;

Individual agency chronologies will be collated to produce an Integrated Chronology, which will be used to inform potential learning.

Request to identify staff to attend the Reflective Learning Workshop

Once our information gathering stage is complete, we plan to hold a Reflective Learning Workshop involving **front-line workers and supervisors who had direct involvement with the child and / or their family**. I would, therefore, be grateful if you could identify and confirm the name and contact details of all relevant staff in your organisation.

Submission

Please submit your agency's completed forms via email to [insert name and email address] no later than **[insert deadline].**

If you require any further information or need any support completing the chronologies, please contact [insert name and contact details].

Yours sincerely,

[Insert signature, name and title]

Enc:

- Case Summary
- Chronology Templates – Key Events and Organisational Changes
- Guidance on completing the chronologies

Appendix 10: Guidance on Completing the Chronologies

Guidance for Agencies Completing the Chronologies

Background Information

The Purpose of Child Safeguarding Practice Reviews

Working Together to Safeguard Children 2023 provides a useful summary of the purpose of Child Safeguarding Practice Reviews:

"The purpose of reviews of serious child safeguarding cases is to identify improvements to be made to safeguard and promote the welfare of children. … Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.

Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose, including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings. These processes may be carried out alongside reviews or at a later stage."

Definition of a Serious Child Safeguarding Case

Working Together 2023 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 (although this is not an exhaustive list). *Working Together 2023* 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.

Purpose of this Guidance

This guidance is intended to provide specific guidance to agencies when asked to complete a Key Event or Organisational Chronology for a Local Child Safeguarding Practice Review. The aim is to ensure a professional standard and consistency across agencies.

Who should complete the Chronology?

Chronologies should be completed by **a senior member of staff who has had no involvement with the case.** This individual should have access to all relevant information and records relating to the case and should be given the opportunity to query facts with staff where necessary.

A senior member of staff within the agency should **quality assure and sign off the chronology** prior to its submission.

Purpose of the Chronologies

What is a Chronology?

A chronology is a succinct summary and overview of the significant dates and events in a child's / young person's life. Chronologies are also used to capture significant organisational changes.

When undertaking a local child safeguarding practice review all relevant agencies will usually be asked to complete a 'Key Events Chronology' of their agency's involvement **and** a chronology of any organisational changes which may have impacted on frontline practice during the same period.

Individual agency chronologies will be collated to produce an Integrated Chronology.

Why are Chronologies Useful?

Children and young people are most effectively safeguarded if professionals work together and share information. Single factors in themselves are often perceived to be relatively harmless. However, if these factors multiply and compound one another, the consequences can be serious, and on occasions, devastating.

Chronologies are used as an analytical tool to help understand the impact of events and changes on a child / young person's developmental progress. They can reveal risks, concerns, patterns and themes, strengths and weaknesses within a family, and can identify periods of professional involvement, support and its effectiveness. Chronologies enable the Review Team to gain a more accurate picture of the whole case and highlight gaps and missing details that require further assessment and identification.

It is recognised that the relevance and / or significance of an event can change over time. A historical event which appeared insignificant or irrelevant at the time may become highly significant in the light of further information or subsequent events.

How to Complete a Chronology

What is a Key Event Chronology?

A 'key event' is a significant incident that impacts on the child's / young person's safety and welfare, circumstances or home environment. This will require a professional decision and / or judgement based upon the child / young person and family's individual circumstances.

It is crucial that the information recorded in a chronology is **relevant and succinct** to avoid key events becoming lost in a mass of insignificant and irrelevant detail.

The events or incidents that should be recorded will vary from case to case depending upon the nature of the risks and harm. The following are some examples, but it should be noted that this is not an exhaustive list:

- Contacts or referrals about the child / young person / family;
- Assessments undertaken;
- Strategy Discussions
- Meetings and Child Protection Conferences;
- Child Protection enquiries and Section 47 investigations;
- Non-accidental injury and significant injury or neglect events;
- Attendance / admittance to hospital;
- Births, deaths, serious illness of adults and children and young people in the family;
- House moves;
- Changes in family composition, including new partners, separations, non-family members moving into family home;
- Criminal proceedings and outcomes;
- Civil proceedings involving the family;
- Change in school and school exclusions;
- Change in GP;
- Self-referrals and any referrals to other agencies / teams;
- Court proceedings and changes in legal status, including periods when a child / young person became looked after by the local authority;
- Police logs detailing relevant incidents at family home or in relation to family members, such as reported incidents of domestic abuse, drunken / anti-social behaviour;
- Child / young person's absconding behaviour / missing from home;
- Attempted suicide or overdose of child / young person or family member;
- Specific support offered to family;
- Events showing capacity of family to work in partnership and engage with professionals;
- Frequent presence of unknown adults;
- Any event in the child's life deemed to have a significant effect on them, such as separation from main carer leading to poor attachment.

What Time Period should the Chronology Cover?

The time period covered by each review will be identified based on the potential learning likely to be achieved. There is little value in identifying weaknesses in professional practice or procedures that have already changed. All agencies will be informed of the relevant timeline when asked to complete the chronology template: this will usually be included in the 'Case Summary' provided or the Terms of Reference. Please focus on this time period when completing your chronology. However, do

include any Key Events outside of this time period if they are likely to be required to understand the pattern of child neglect and whether early help interventions could have been beneficial.

In some cases, a chronology for a child / young person may start with events that occurred prior to his or her birth.

Why Do I Also Need to Complete a Chronology of Organisational Changes?

The purpose of a local Child Safeguarding Practice Review is to identify improvements to current safeguarding arrangements to prevent, or reduce the chance of, similar incidents in the future. Improvements may be linked to practice issues but they frequently also require changes to the organisational and "systems" factors that shaped behaviour (such as organisational/team aims or culture and the level of resources available to deliver services.)

The chronology of significant organisational changes is, therefore, important to help to identify where organisational and "systems" factors influenced actions.

Again, it is crucial that the information on organisational changes recorded in a chronology is **relevant and succinct** to avoid key events becoming lost in a mass of insignificant and irrelevant detail.

Disclosure of Chronologies

Agencies should be aware that a request may be made by the Police or Court for chronologies to be disclosed when information is being gathered for a criminal case. If requested, we will not provide a copy of your documents but will, instead, forward your contact details to the officer seeking disclosure so that direct contact can be made.

Appendix 11: Template email – Invitation to Reflective Learning Session

Dear Colleague,

Reflective practitioner session

We are undertaking a local Child Safeguarding Practice Review regarding **INSERT CHILD/CHILDREN NAME & DOB** The purpose of the review is to identify improvements to current safeguarding arrangements to prevent, or reduce the chance of, similar incidents in the future.

We recognise that first-hand experience from those working with the child and their family is essential to ensure we have a full understanding. All professionals who have had **direct involvement** with the child and/or family are, therefore, being invited to attend a Reflective Practitioner Session. This has been arranged for:

ADD DATE & TIME

This will be an opportunity for professionals from different agencies to discuss why things happened, or did not happen, and what could be done differently in a respectful, positive and supportive environment. **As a professional involved in the case it is important that you attend.** If you are unable to attend for any reason, please can you nominate a representative from your agency and inform us of who this is going to be.

Please see attached briefing, which explains more about the purpose and structure of the session. However, if you have any questions or concerns, please do not hesitate to contact **ADD CONTACT DETAILS**

Kind regards,

Appendix 12: Briefing on the Reflective Practitioner Session

About the Reflective Practitioner Session

The purpose of a local Child Safeguarding Practice Review of a serious incident is to identify improvements to current safeguarding arrangements to prevent, or reduce the chance of, similar incidents in the future. It is NOT looking to attribute blame to individuals or organisations.

The Reflective practitioner session is a crucial part of the review process. This meeting provides a forum for frontline professionals and operational managers to come together in a respectful, positive and supportive environment to consider the circumstances surrounding the case and the reasons actions were taken.

Important Principles

- **The session will provide a supportive environment that encourages reflection**

The meeting will be led by an independent Lead Reviewer for the case. All Lead Reviewers are expected to ensure the session provides a respectful and supportive environment and they will intervene if anyone starts discussing blame or focusing on individual practice.

- **All observations and comments will be anonymous**

We understand that participants may feel uncertain or anxious and would like to assure you that comments made on the day will not be attributable to individuals. Any themes and comments will be anonymised in the final report.

- **We will be capturing good practice as well as what needs to change**

While the focus of the review is to identify ways to improve safeguarding practice, the review will also be seeking to identify where practice is good and working well.

The Structure of the Session

The structure of the session will vary depending on the case but is likely to follow the following format:

- **Considering the Factual Information**

The Lead Reviewer will give an overview of the key facts and events in respect of the case and participants will be asked to agree/change and discuss these. This may include querying the factual accuracy, adding to the information, or questioning it. The aim is to reach an understanding of the professional intervention and key events that the child and family experienced.

- **Considering the Child's Lived Experience**

With this knowledge, the group will spend a short time exploring the "lived experience of the child/children". The enables participants to view what happened from the child's perspective.

- **Identifying Key Issues and Themes**

The session will identify and discuss the key issues and themes. These will usually be practice issues that have emerged within the case which can be transposed into working with families more generally, and/or organisational and "systems" factors that shaped behaviour (such as organisational/team aims or culture and the level of resources available to deliver services).

- **Identifying Learning**

The final part of the session will focus on identifying areas of learning for professional practice in the future. Examples of good practice will also be highlighted and included for wider dissemination in the review report.

Practitioner Support

Taking part in a review can be upsetting or distressing for some people. Should you feel that you need support prior to or after the session you should speak with your line manager or colleagues who will be able to offer support/signpost for support services available to you.

Appendix 13: Sample Agenda for a Reflective Practitioner Session

Reflective Practitioner Session

Date / Time
Venue
Agenda

No	Time	Item
	9:45am	**Registration**
1.	**10:00am**	**Welcome and Introductions**
2.	**10:05am**	**Purpose of Session:** • *To understand the child's story and what life was like for them;* • *To consider what happened in the case from a multi-agency practitioner and agency perspective;* • *To identify what decisions were taken/not taken and the context;* • *To identify what could have been done differently;* • *To identify the key learning points/findings;* • *To identify improvements which are needed and to consolidate good practice, in line with the Terms of Reference.* **Principles for Working Together**
3.	**10:20am**	**Brief Outline of Terms of Reference, Methodology / Overview of the Case and Thoughts so Far - (*Lead Reviewer)*** **Child's Lived Experience (Timeline/story)**
4.	**11:00am**	**Agency Involvement with the Case:** • Who knew what when? • What is new information? • Any surprises? ➢ What? ➢ Why? • Significant Influencing Factors?
5.	**11:30am**	**Break**
6.	**11:45am**	**Key Lines of Inquiry and Questions** *Identify Key Issues for Improving Practice*
7.	**12:40pm**	**Summary of Key Feedback Points and Any Other Reflections**
8.	**13:00pm**	**Evaluation and Close**

Appendix 14: Need to Know Process