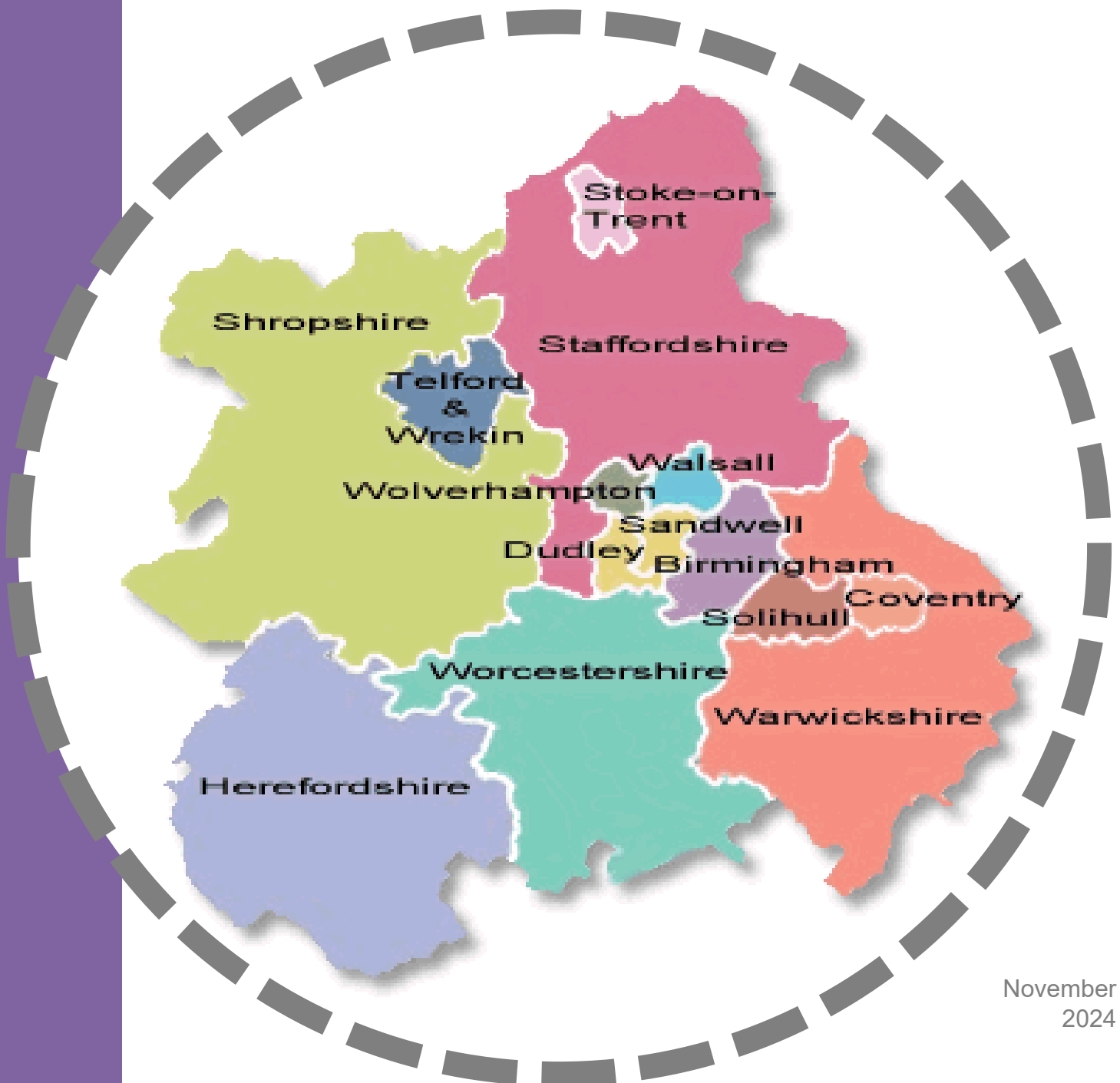


# Local Child Safeguarding Practice Reviews

## Regional Toolkit & Practice Guidance



November  
2024

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## Who is the Toolkit and Guidance for?

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This regional toolkit and guidance was produced on behalf of the Safeguarding Partners, and agencies involved in Multi-Agency Safeguarding Arrangements. The guidance is aimed at those specifically involved in commissioning, managing or contributing to Rapid Reviews and Local Child Safeguarding Practice Reviews, such as Independent Lead Reviewers, Review Team members, those providing information reports on behalf of their organisation as well as those responsible for quality assuring and embedding the learning from the review process.

## About this Toolkit and Guidance

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This guidance provides Safeguarding Children Partnerships across the wider West Midlands region with a set of tools and helpful guidance to assist in commissioning and disseminating 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*.

The toolkit and guidance has been endorsed by Safeguarding Partners across the fourteen local authorities detailed below: this regional guidance will continue to be reviewed and updated to reflect changes in national guidance and emerging good practice.



# 1. Introduction and Context

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## 1.1 Introduction

- 1.1.2 The Children and Social Work Act 2017 introduced a new legal framework in respect of local safeguarding arrangements for children. Responsibility for how a system learns lessons from serious child safeguarding incidents now rests at a national level with the Child Safeguarding Practice Review Panel (the National Panel) and at a local level with the three Safeguarding Partners (Integrated Care Boards, Police and Local Authorities).
- 1.1.3 Local areas are required to conduct a Rapid Review whenever a child has died or been seriously harmed and abuse or neglect is known or suspected. This Rapid Review should allow the Safeguarding Partners to consider the potential for learning and to decide whether to also undertake a *Local Child Safeguarding Practice Review (LCSPR)*.
- 1.1.4 Any further review of a case should be referred to as a Local Child Safeguarding Practice Review and should meet the requirements of a LCSPR. **There are no other types of review needed or allowed within *Working Together 2023*.** Local areas may also choose to undertake a LCSPR in other circumstances where they feel learning may be identified.
- 1.1.5 This toolkit provides professionals with a guide to follow when undertaking or participating in a Rapid Review and / or Local Child Safeguarding Practice Review. It highlights the statutory elements outlined in *Working Together to Safeguard Children 2023* and outlines responsibilities for key people at each stage of the process. It also includes useful template documents and letters that can be easily adapted to meet the specific circumstances of each individual case.
- 1.1.6 The guidance and template documents / letters should not be seen as a prescriptive process or approach. Instead, local areas are encouraged to use this guidance as a toolkit to help them choose the most appropriate methodology for each individual case whilst ensuring they follow good practice around key aspects such as engagement and report writing.

## 1.2. Purpose of Child Safeguarding Practice Reviews

- 1.2.1 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.
- 1.2.2 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.

### 1.3. Definition of a Serious Child Safeguarding Case

- 1.3.1 *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.
- 1.3.2 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.<sup>1</sup>
- 1.3.3 *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.
- 1.3.4 Child perpetrators may be the subject of a review, if the definition of a serious child safeguarding case is met.

### 1.4. Criteria for a Local Child Safeguarding Practice Review

- 1.4.1 Safeguarding Partners are required<sup>2</sup> to consider certain criteria and guidance when determining whether to carry out a Local Child Safeguarding Practice Review. They **must take into account** whether the case:
- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified;
  - highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children;
  - highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children;
  - is one which the National Panel have considered and concluded that a local review may be more appropriate.
- 1.4.2 They should also **have regard to** the following circumstances:
- where the Safeguarding Partners have cause for concern about the actions of a single agency;
  - where there has been no agency involvement and this gives the Safeguarding Partners cause for concern;
  - where more than one local authority, police area or Integrated Care Board is involved, including in cases where families have moved around;
  - where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.<sup>3</sup>
- 1.4.3 Meeting the criteria does not mean a Local Child Safeguarding Practice Review must automatically be undertaken. Instead, the Rapid Review process outlined in this

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<sup>1</sup> This is not an exhaustive list.

<sup>2</sup> By the Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018.

<sup>3</sup> This includes children's homes (including secure children's homes) and other settings with residential provision for children; custodial settings where a child is held, including police custody, young offender institutions and secure training centres; and all settings where detention of a child takes place, including under the Mental Health Act 1983 or the Mental Capacity Act 2005.

document will be followed to determine whether a review is appropriate (i.e. whether there is potential to identify improvements.)

- 1.4.4 Local Child Safeguarding Practice Reviews may also be undertaken for cases which do not meet the definition of a 'serious child safeguarding case' if they raise issues of importance that could generate learning. *Working Together 2018*, for example, suggests they might take place where there has been good practice, poor practice or where there have been 'near miss' events.
- 1.4.5 A Local Child Safeguarding Practice Review should be undertaken whenever a Rapid Review identifies the potential for additional learning. This may be a **proportionate** review. **There are no other types of review needed or allowed within *Working Together 2023***.
- 1.4.6 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.
- 1.4.7 There may be times where another statutory review is also required: this could be a Domestic Homicide Review, a Safeguarding Adult Review, or a Multi-Agency Public Protection Serious Case Review. The case may also need to be considered by the statutory Child Death Review arrangements. *Appendix 1* provides a summary of the different statutory reviews.
- 1.4.8 Where more than one statutory review arises from a single or linked incident, it may be advisable to undertake a combined review. When undertaking such a review it is important that the key requirements of each statutory review process are clearly identified and met. It is equally important to establish and agree the line of accountability and governance of the review process, including the management process for finalisation, approval and publication.

## 1.5. Approach and Principles

- 1.5.1 Each case will be examined individually to determine the most appropriate methodology to identify and maximise learning.
- 1.5.2 All areas will conduct Local Child Safeguarding Practice Reviews in line with good practice and the principles of the systems methodology recommended by the Munro Report.<sup>4</sup> This includes the advice outlined in *Working Together 2023* and its predecessor documents as well as the good practice principles described in the SCIE / NSPCC 'Quality Markers'<sup>5</sup>.
- 1.5.3 Decisions on whether to undertake a review will be made transparently and the rationale shared with all relevant partners, including families.

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<sup>4</sup> The systems approach in this guidance was developed based on the model cited in the Munro Report: this is described in SCIE Guide 24: '*Learning together to safeguard children: developing a multi-agency systems approach for case reviews*' by Dr Shelia Fish, Dr Eileen Munro and Sue Bairstow (January 2009).

<sup>5</sup> 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.

- 1.5.4 The child will be placed at the centre of the process. The characteristics of the child's identity – such as race, ethnicity, sexual orientation, gender and disability – will be considered alongside any relevant cultural context.
- 1.5.5 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.
- 1.5.6 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.
- 1.5.7 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.
- 1.5.8 All participants in the review process will be asked to declare any potential conflicts of interest and may be expected to sign, and adhere to, a confidentiality agreement. An example confidentiality agreement is included as [Appendix 2](#).

## **1.6 Strategic Leadership and Governance**

- 1.6.1 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.
- 1.6.2 Many areas will have a standing Child Safeguarding Practice Review Group, or equivalent, made up of representatives from the Safeguarding Partners in their area along with any relevant safeguarding experts from partner agencies. Other areas may only convene their Group when a serious incident is referred to them. This Group will undertake a Rapid Review of each serious incident referred to them and will take responsibility for commissioning and overseeing any Local Child Safeguarding Practice Reviews. This will include monitoring case progression, quality assurance and publication of final reports, and ensuring effective oversight of the implementation of learning.
- 1.6.3 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.<sup>6</sup>

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<sup>6</sup> 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 or care leaver (up to their 25<sup>th</sup> birthday) has died, whether or not abuse or neglect is known or suspected.



## 2. Information Sharing

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- 2.1.1 Information sharing is essential to safeguard and promote the welfare of children and young people. Effective Child Safeguarding Practice Reviews are dependent on all relevant partners sharing the information they hold about the case and associated professional practice.
- 2.1.2 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.
- 2.1.3 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.
- 2.1.4 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.
- 2.1.5 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.
- 2.1.6 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.
- 2.1.7 In the case of any disagreement or failure to comply with a formal information request, the Independent Lead Reviewer or a Review Team member will refer the issue to the Child Safeguarding Practice Review Group (or local equivalent) who will seek to resolve this with the strategic Safeguarding Lead for the agency concerned. If a prompt resolution cannot be found, the issue will be escalated to the Safeguarding Partners for formal action.

### 3. Timescale for Completion of the Review

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- 3.1.1 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.
- 3.1.2 A Rapid Review and decision on all referrals should be made within the timescales outlined in guidance from the National Panel (currently **within 15 working days**) and all statutory Local Child Safeguarding Practice Reviews should be completed no later than **six months** from the date of the decision to initiate a review. Reviews should be proportionate and it should, therefore, be possible to complete less complex cases more quickly<sup>7</sup>.
- 3.1.3 A thorough Rapid Review may mean that there is no need for a separate Local Child Safeguarding Practice Review and local areas can move quickly to implement learning across the system.
- 3.1.4 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 Child Safeguarding Practice Review Group / Safeguarding Partners as soon as they arise. Any potential delays beyond six months should be discussed with the National Panel.

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<sup>7</sup> [Child Safeguarding Practice Review Panel guidance for safeguarding partners – September 2022](#)

## 4. Deciding whether to undertake a Child Safeguarding Practice Review

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### 4.1 Notification

- 4.1.1 A formal notification should be made to the National Panel within 5 working days if a child dies or is seriously harmed in the local authority area (or outside of England while they are normally resident in the local authority area) *and* abuse or neglect is known or suspected.
- 4.1.2 While the responsibility to notify rests on the local authorities, it is for safeguarding partners to agree which incidents should be notified to the National Panel. Where there are disagreements the dispute resolution protocol should be followed.<sup>8</sup>
- 4.1.3 Where an agency other than the local authority becomes aware of an incident that appears to meet the criteria for notification, they should discuss this with their local authority counterparts to reach an agreement on whether or not to notify. Guidance on whether to notify an incident is included in *Document 1*.
- 4.1.4 Where a local authority makes a formal notification to the National Panel, it must always share this with the relevant local Safeguarding Partners. Safeguarding Partners are required to promptly undertake a Rapid Review on all notified serious incidents. Where an incident has not been notified and does not meet the criteria for notification, there is no requirement to undertake a Rapid Review.
- 4.1.5 Agencies should inform the relevant designated single point of contact for the Safeguarding Partners of any other serious incident which they think should be considered for a Child Safeguarding Practice Review, using the *Referral Form (Document 1a)*.
- 4.1.6 Where a case involves services delivered across more than one safeguarding partnership, the Safeguarding Partners should liaise and agree which partnership will take the lead in conducting the Rapid Review. Normally this would be the safeguarding partnership in the area where the child is usually resident. Consideration should be given to how any other Safeguarding Partners might be included in decision making, including whether to undertake a joint LCSPR.

### 4.2 Rapid Review

- 4.2.1 Rapid reviews should identify, collate, and reflect on the facts of the case as quickly as possible in order to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning.
- For safeguarding partners, the Rapid Review should conclude with a decision about whether or not an LCSPR should be commissioned using the criteria set out in *Working Together 2023*.
  - If the decision is to commission an LCSPR, the key lines of enquiry and the questions that are to be answered by the review process should be set out in the conclusion to the Rapid Review.
  - Good practice is where partnerships identify what has been learnt and how this learning will be disseminated and acted on across the local partnership.

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<sup>8</sup> Local authorities have a separate duty to notify the Secretary of State and Ofsted where a looked after child or care leaver has died, whether or not abuse or neglect is known or suspected.

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

4.2.3 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.

### **4.3 Initial Scoping, Information Sharing and the Securing of Records**

4.3.1 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, a *Template for Initial Scoping and Information Sharing* (Document 2) is included as part of this toolkit along with a *Sample Letter* to accompany the template (Document 2a).

4.3.2 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.

4.3.3 It is advisable to send out the *Template for Initial Scoping and Information Sharing* (Document 2) to all relevant agencies **within 2 working days** of receiving the referral, along with an accompanying letter that briefly outlines the referral and explains the purpose of this initial scoping (Document 2a). (It is advisable to send this out as early as possible to give agencies the maximum time to complete the scoping request.)

4.3.4 Agencies should prioritise completion of the scoping request and return the form **within 5 working days**. This builds in time to produce an integrated chronology of key Practice Learning Events and a Genogram in advance of the Rapid Review.

4.3.5 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. (This request is included in the template letter – Document 2a). Where access to the records is required for ongoing case work, a copy should be made and secured.

4.3.6 There is no expectation to involve families in the Rapid Review.

### **4.4 Setting the Date of the Rapid Review Meeting**

4.4.1 Some partnerships may have a standing Group to undertake Rapid Reviews and oversee LCSPRs. Other areas may have to convene an extraordinary meeting to undertake the Rapid Review.

4.4.2 The date of the Rapid Review meeting should be set as soon as the *Templates for Initial Scoping and Information Sharing* have been sent out. The Rapid Review meeting should be scheduled **between 7 and 13 working days** of receiving the referral. This will allow for analysis of the *Initial Scoping and Information Sharing* to help identify the key practice learning events to inform the Rapid Review, whilst also allowing sufficient time to prepare and quality assure the necessary documents for the National Panel.

## 4.5 Useful Documentation

- 4.5.1 The following key documents can greatly assist understanding, analysis and the decision making at the Rapid Review meeting:
- the *Local Authority Serious Incident Notification* to Ofsted, the Department for Education and the National Panel in relation to the incident;
  - copies of the completed *Initial Scoping and Information Sharing* templates from relevant agencies;
  - Family Genogram (see example in [Appendix 3](#));
  - Chronology of Key Practice Learning Points.
- 4.5.2 Wherever possible the documentation should 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.

## 4.6 The Rapid Review Meeting

- 4.6.1 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 three statutory Safeguarding Partners**. The participants at the Rapid Review meeting, their role, and the organisation they represent will be recorded in the Rapid Review documentation. The omission of any agency whose involvement would usually be expected will be noted and an explanation for their absence will be provided.
- 4.6.2 Where there is a potential overlap with another statutory review (such as a Domestic Homicide Review, a Safeguarding Adult Review, or a Multi-Agency Public Protection Serious Case Review), it is advisable to invite appropriate local experts / commissioners to attend the Rapid Review meeting.
- 4.6.3 The Rapid Review meeting should:
- review the facts about the case (many areas have found it helpful to prepare a short chronology of the key Events in advance);
  - discuss whether any immediate action is needed to ensure children's safety;
  - identify immediate learning that can be acted upon and agree how this will be shared;
  - consider the potential for identifying improvements to safeguard and promote the welfare of children;
  - decide whether or not to undertake a Child Safeguarding Practice Review. Clear reasons for this decision are required.
  - If the decision is to proceed with a Child Safeguarding Practice Review, an appropriate scope should be specified, with some identified key lines of enquiry.

An example [agenda for a Rapid Review meeting](#) is included as [Document 3](#).

- 4.6.4 Whilst recognising the time constraints, the Rapid Review should seek to consider the following issues:
- What was the child's true lived experience and how can their voice be heard in the review?
  - How was the race, culture, faith, and ethnicity of the child and/or family considered by practitioners and did cultural consideration impact on practice?
  - How did any disability, physical or mental health issues, and any identity issues in the child and/or family impact on the child's lived experience and on practice?

- Were any recognised risk factors present or absent and did they play a significant part in the child's lived experience?
- Are there issues identified that are of national significance? Is a national review considered to be necessary following the Rapid Review? If so, why?
- Does the Rapid Review identify relevant good practice, and should this be disseminated across the system?
- Has the Rapid Review identified clear agency and partnership actions to take forward, especially where the recommendation is not to undertake a full Child Safeguarding Practice Review?

Any relevant national reviews should be referenced and used to support local learning.

- 4.6.5 A thorough Rapid Review may mean that there is no need for a separate Local Child 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. (It is important that this addresses the 'why' issues: *why* events happened as they did, *why* practitioners made certain decisions, and *why* children and families responded as they did);
  - clearly related learning with actions to address any weaknesses;
  - plans for dissemination and implementation of learning.

On concluding a Rapid Review where learning is identified and a further review is not required, consideration should be given to whether, and how, any learning should be shared with the family.

- 4.6.6 From time to time, the National Panel may request the inclusion of additional considerations and these will be incorporated. For example, the request to consider whether, and to what extent, the Covid-19 pandemic may have impacted either on the circumstances of the child or family or the capacity of services to respond to their needs.
- 4.6.7 The analysis and outcome of the meeting should be recorded on the [Rapid Review Template \(Document 4\)](#) and should be shared and agreed by those attending the Rapid Review meeting.

Those responsible for writing up the Rapid Review may wish to refer to the National Panel's ['Rapid Review examples' \(December 2022\)](#). This document includes anonymised examples of how to summarise both the incident and the discussions at the Rapid Review as well as how to set out the immediate actions and learning.

- 4.6.8 There should be a clear process for the ratification of the outcome of the Rapid Review by each of the Safeguarding Partners prior to submission to the National Panel. Where responsibility is delegated within the partner agencies, those holding responsibility need to be clearly identified, have the authority to make decisions on behalf of their agency, and have clear lines of accountability.
- 4.6.9 Areas who have an Independent Scrutineer may wish to ask them to endorse the outcome. However, the responsibility for the decision remains with the three Safeguarding Partners.

## 4.7 Sharing the Outcome of the Rapid Review

- 4.7.1 **Within 2 working days** of the Rapid Review meeting, the Safeguarding Partners should send the completed *Rapid Review Template* to the National Panel (Mailbox.NationalReviewPanel@education.gov.uk) together with a covering letter, see [Sample letter to accompany the Rapid Review Template \(Document 5\)](#).

All relevant information should be incorporated within the Rapid Review template, negating the need to embed any documents or submit additional documentation to the National Panel.

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

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

### Within 2 working days of referral

- *Initial Scoping and Information Sharing Template* sent to all relevant agencies
- Date set for Rapid Review Meeting (*This could be a standing Group responsible for overseeing learning from serious incidents or an extraordinary meeting to undertake the Rapid Review*).

### Within 5 working days

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

### Between 7 and 13 working days of receiving the referral

- **Rapid Review** meeting held to:
  - Review the facts about the case presented in the documentation.
  - Agree any immediate action.
  - Consider the case against the criteria for Child Safeguarding Practice Reviews.
  - Decide whether a local child safeguarding practice review should take place.
  - Complete the *Rapid Review Template* and agree the recommendation.

### Within 15 working days of receiving the referral

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

## **5. Agreeing the Scope and Terms of Reference**

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### **5.1 Agreeing the Scope and Terms of Reference**

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

### **5.2 Time Period**

- 5.2.1 The time period covered by the review should reflect the potential learning likely to be achieved. (There is little value in identifying weaknesses in professional practice or procedures that have already changed). It should, therefore, be as short and as recent as possible. This, however, needs to be balanced against the need to understand the pattern of child neglect and whether early help interventions could have been beneficial. This is particularly important when considering adolescent reviews where harm frequently relates to previous childhood trauma and neglect.

### **5.3 Focus of the Review**

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

### **5.4 Cultural Competence and Intersectionality**

- 5.4.1 Culturally competent practice places children's well-being and protection within their cultural context. The scoping of all reviews will explicitly consider issues related to ethnicity and cultural competence.
- 5.4.2 The potential to learn from issues of intersectionality (the interconnected relationship of social categorisations such as race, gender and sexual orientation together with individual vulnerabilities and adversities) will also be considered.

### **5.5 Methodology**

- 5.5.1 As set out in section 1.6 above, the local 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 selected to meet the specific needs of the case. The key elements of a 'systems approach' methodology are described in Section 8.
- 5.5.2 The Terms of Reference will specify the information collection and collation tools that will be used in the review. This may include Chronologies (of Key Events and/or organisational changes), Information Reports / Learning Templates or both (see Section 8.4-8.6).

### **5.6 Engaging Children and Family Members**

- 5.6.1 Using the information available, and the genogram where available (see Section 7.2), 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.

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

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

## **5.7 Parallel Investigations**

5.7.1 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<sup>9</sup>. It is anticipated that a Local Child Safeguarding Practice Review will go ahead unless there are clear reasons not to (although publication may need to be delayed).

5.7.2 Where there are criminal proceedings, the availability of witnesses should not prevent the LCSPR from being progressed. The review should focus on identifying and embedding learning with any gaps from not undertaking particular interviews being addressed later.

5.7.3 Under *Working Together 2023* there is greater discretion as to when a Local Child Safeguarding Practice Review should take place and who does it. This enables greater flexibility in designing the right review methodology whilst meeting statutory obligations. Where there are parallel investigations, this is best considered at the scoping stage to reduce duplication and the impact on children and families and to maximise learning.

## **5.8 Legal Advice**

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

## **5.9 Timetable**

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

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<sup>9</sup> For example, Domestic Homicide Reviews, multi-agency public protection arrangement reviews, Safeguarding Adult Reviews or health 'serious untoward incident' processes.

## **6. Appointing the Lead Reviewer and Review Team**

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### **6.1 The Lead Reviewer**

- 6.1.1 An independent Lead Reviewer will usually be appointed to manage the review process, chair meetings of the Review Team, facilitate the Learning Workshops and author the final report. However, a Lead Reviewer is not a requirement and may not be needed where shorter 'proportionate' reviews are conducted.
- 6.1.2 The Safeguarding Partners will inform the National Panel, Ofsted and the Department for Education of the name of any reviewer commissioned via email to:
- [Mailbox.NationalReviewPanel@education.gov.uk](mailto:Mailbox.NationalReviewPanel@education.gov.uk)
  - [SCR.SIN@ofsted.gov.uk](mailto:SCR.SIN@ofsted.gov.uk)
  - [Mailbox.CPOD@education.gov.uk](mailto:Mailbox.CPOD@education.gov.uk)

### **6.2 The Review Team**

- 6.2.1 For complex reviews, a small, multi-agency Review Team will usually be established to assist the review process. This will include a representative from each of the Safeguarding Partners along with any relevant subject matter experts, depending on the case.
- 6.2.2 The Review Team will support the Lead Reviewer to scrutinise the information provided by agencies. The Review Team will also provide local context and challenge to the analysis of professional practice and the identification of learning. Where an agency report is not of the quality expected, the Lead Reviewer will make contact with the relevant agency and ask for the report to be revised and resubmitted in a timely manner.
- 6.2.3 The police representative will be responsible for liaising with the Senior Investigating Officer, Crown Prosecution Service, and for co-ordination of family liaison.

## 7. Engaging Children and Family Members

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### 7.1 Approach and Principles

- 7.1.1 *Working Together 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.
- 7.1.2 The characteristics of the child's identity – such as race, ethnicity, sexual orientation, gender and disability – will be considered when engaging with the child / family. These characteristics will also be considered when undertaking analysis as part of the review. For example, the extent to which the cultural background of a child and / or family may have impacted on professional decision making.
- 7.1.3 In line with good practice<sup>10</sup> 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.
- 7.1.4 Family engagement will be included as a standing item at all Review Team meetings. The Review Team will also identify an individual who will take responsibility for co-ordinating communication with family members.

### 7.2 Identifying the Family Network

- 7.2.1 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. (An example genogram is included in [Appendix 3.](#)) This will be shared with other agencies at Review Team meetings and in any Reflective Learning Workshop (see Section 8.9) and will be updated based on any additional information on the family provided by these agencies. The genogram will not be included in the final published report.

### 7.3 Making Initial Contact with the Family

- 7.3.1 Family members, including surviving children, will be informed of the review and invited to contribute unless there is a strong reason not to do so. The initial planning meeting (described under Section 5) will discuss family involvement and agree an approach that will sensitively manage their expectations and ensure they understand the process.
- 7.3.2 Personal contact should be made whenever possible by the most appropriate professional and the family provided with a letter and / or leaflet to explain and introduce the review process and Lead Reviewer. See [Sample Letter to Family Members \(Document 7\)](#) and [Sample Leaflet on Child Safeguarding Practice Reviews \(Document 8\)](#).

### 7.4 Conversations with Family Members

- 7.4.1 Family engagement will normally be led by the Lead Reviewer and conversations should ideally take place before the Learning Event (described in Section 8.9) so that

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<sup>10</sup> This includes, but is not limited to, the SCIE / NSPCC Quality Marker 4 on Informing the Family and Quality Marker 12 on Family Involvement.

the family's views can be included alongside the analysis of professional practice. Where a Lead Reviewer is not commissioned, the local area will nominate the organisations / individuals responsible for liaising with the family. However, engagement may not be possible until the outcome of any criminal proceedings.

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

## 8. Methodology

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### 8.1 The 'Systems Methodology' and Expectations of Agencies

- 8.1.1 *Working Together 2023* does not specify the methodology that should be used in Local Child Safeguarding Practice Reviews but there is an explicit expectation that 'principles of the systems methodology recommended by the Munro Report' will be 'taken into account' by the Safeguarding Partners when agreeing the method by which the review will be conducted.
- 8.1.2 This section describes the key elements of a 'systems approach' that will be considered when determining the methodology for Local Child Safeguarding Practice Reviews in the wider West Midlands area. These are consistent with both the guidance in *Working Together 2023* and the principles of the systems methodology recommended by the Munro Report.<sup>11</sup>
- 8.1.3 Each case will be examined individually and the methodology will be selected 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.

### 8.2 Analysis – asking the 'why' questions

- 8.2.1 The purpose of a LCSPR is to **analyse** the case not simply to describe what happened. Whatever methodology is adopted, the focus will be on asking questions such as:
- Why were key decisions made?
  - Why were critical observations missed or simply ignored?
  - Why did circumstances exist which caused sometimes terrible detriment to one or more children?

These questions of 'why' are crucial and must be addressed in all reviews. While understanding what happened is important, it is critical that reviews address *why* events happened as they did, *why* practitioners made certain decisions, and *why* children and families responded as they did.

- 8.2.2 The focus will be on what caused something to happen and how it can be prevented from happening again. Lead Reviewers and Review Teams will probe behind the first information or first answers they are given, whether from service users or other practitioners. Their analysis of events will ask these 'second questions' in order to get the heart of what was missing, why and how change can be achieved. For example, rather than noting that there was "a lack of professional curiosity" in a case, the review will seek to establish why practitioners were not sufficiently curious and whether any barriers existed to practitioners asking questions, following up issues, or engaging with families.
- 8.2.3 Systems factors will be considered. This includes policies, procedures and organisational changes as well as leadership, culture, and human motivations (such

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<sup>11</sup> The systems approach described in this guidance was developed based on the model described in SCIE Guide 24: *Learning together to safeguard children: developing a multi-agency systems approach for case reviews* by Dr Shelia Fish, Dr Eileen Munro and Sue Bairstow (January 2009) and following research into best practice around Serious Case Reviews. It incorporates elements from a number of areas but has a particular debt to the model described by Essex Safeguarding Children Board.

as the impact of fear, exhaustion, overwork etc.). The review will consider relevant failings and good practice and policy at all levels.

### **8.3 Agency Action and Expectations**

8.3.1 All agencies who provided services to the child and family during the time period specified in the Terms of Reference will be formally requested to participate in the review process. Agency engagement will be dependent on the extent of their intervention, the type of review commissioned, the chosen methodology and the specific Terms of Reference.

8.3.2 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.

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

### **8.4 Information Collection and Collation**

8.4.1 The Terms of Reference will specify the information collection and collation tools that will be used in the review. This may include chronologies, information reports or similar templates, and the use of other evidence.

### **8.5 Chronologies**

8.5.1 Relevant agencies may 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.

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

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

8.5.4 Chronologies will be used to as a tool to support **analysis** of events and to identify key Practice Learning Events. Care will be taken to ensure the review does not become bogged down with detailed chronologies at the expense of this important reflection.

### **8.6 Information Reports, Learning Templates and Other Evidence**

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

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

8.6.3 Reviews may wish to draw on wider evidence related to the case. For example, the context of the local area, data and analysis related to agencies and services, national and international evidence, and learning from other Local Child Safeguarding Practice Reviews and / or national reviews.

## **8.7 Review Team Quality Assurance of Agency Submissions**

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

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

## **8.8 Establishing Key Themes**

8.8.1 Using the chronologies and/or analysis in the information reports/learning templates, the Review Team will discuss the case in detail and confirm and agree the **Key Themes for Analysis** building on learning from the Rapid Review and any lines of enquiry that may have been developed as part of the Terms of Reference. These themes will examine the 'why' questions. They should be as few as practicable and focus on core learning. The key themes should identify issues of practice that have emerged within the case which can (i) be transposed into working with families more generally and (ii) give insight into the systems which operate formally or informally within safeguarding practice. Some examples might be "making space and time for children" or "the use of assessments to inform future interventions".

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

## **8.9 Reflective Learning Workshop**

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

## **8.10 Preparing for a Learning Workshop**

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

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

8.10.3 *Invitations to Reflective Learning Workshop (Document 15)* will be sent to all participants giving plenty of notice. This is likely to be accompanied by a short briefing document which explains the purpose of the event and the importance of attending (*Document 16*).

## 8.11 The Structure of a Learning Workshop

8.11.1 Reflective Learning Workshops may be held ‘face to face’ or virtually.

Where a ‘face to face’ meeting is held, the Reflective Learning Workshop will normally be **undertaken over half a day**, although a more complex case may require an additional half day. See the *Sample Agenda for a Reflective Learning Workshop (Document 17)*.

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

8.11.2 The use of ‘worksheets’ can be beneficial helping participants to focus on learning, undertake preparation, capture key points during the event, and provide post-event feedback. See *Example Worksheets for a Reflective Learning Workshop (Document 17a)*.

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

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

- the information compiled about the family in terms of incidents and professional interventions with an opportunity for participants to query the factual accuracy, to add information and to agree changes;
- the “lived experience of the child/children”. This enables participants to view what happened from the child’s perspective<sup>12</sup>;
- 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.

8.11.5 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.

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

## 8.12 Conversations with Key Practitioners

8.12.1 Where an individual with important information to contribute to the review is unable to participate in a Reflective Learning Workshop, arrangements may be made to

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<sup>12</sup> As outlined under section 7, this is an important requirement of *Working Together 2023* as well as good practice in child safeguarding practice reviews.



facilitate a conversation with the Lead Reviewer to enable them to contribute to the learning.

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

### **8.13 Practitioner Feedback**

8.13.1 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.

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

## 9. The Report

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### 9.1 The Report

- 9.1.1 Safeguarding Partners are required to publish the learning from all Local Child Safeguarding Practice Reviews. The Lead Reviewer will normally draft a formal report with publication in mind: *Guidance on Drafting the Report*, including good practice, is included as *Document 18*.
- 9.1.2 Reports should be focused and succinct. They should contain enough information to provide a clear context for the learning and should reflect the perspective of the child and the family as well as the views of practitioners. The report should focus on analysis of both practice and system issues and should clearly identify any learning arising from the review.
- 9.1.3 Reports should meet any requirements specified in the agreed Terms of Reference for the review and, as a minimum, should also succinctly include<sup>13</sup>:
- a brief overview of what happened and the key circumstances, background and context of the case. This should be concise but sufficient to understand the context for the learning and recommendations;
  - an analysis of **why** relevant decisions by professionals were taken, including the conditions in which practice took place;
  - 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. (This should include local learning as well as any implications for national policy and practice).
- 9.1.4 Reports should not contain information that could be harmful to any individual if made public. 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.
- 9.1.5 Where the views of surviving children or family members have not been included in the review, a short statement should be included detailing the reasons why.
- 9.1.6 The Review Team will be responsible for ensuring the draft report has met the agreed Terms of Reference, is succinct and focused on improving local safeguarding arrangements.
- 9.1.7 The final report should be formally approved by the three statutory Safeguarding Partners.

### 9.2 Identifying Recommended Improvements

- 9.2.1 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. Any implications for national policy or practice should be clearly highlighted.

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<sup>13</sup> This guidance draws on national evaluations of best practice around Serious Case Reviews and the Practice Guidance issued by the National Child Safeguarding Review Panel on 5 April 2019 as well as the 2022 *Child Safeguarding Practice Review Panel guidance for safeguarding partners*.

- 9.2.2 This learning will then be developed into formal recommendations that will also form part of the final report. In some instances, the Lead Reviewer and Review Team may develop the formal recommendations. However, other areas in the wider West Midlands may choose to convene a dedicated group to consider the learning and how this can be developed into meaningful recommendations. These groups will be able to engage key strategic stakeholders and consider the potential learning in the context of wider operational and strategic developments: this will ensure that recommendations are focused on the issues that will make a real difference and, therefore, maximise the opportunity to deliver meaningful change.
- 9.2.3 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.
- 9.2.4 Recommendations should clearly articulate how change might come about and how the effectiveness of any change in practice will be assessed and measured.
- 9.2.5 Time will be allowed to ensure key individuals and the family have sufficient time to read the report in advance of publication. While this process will not change the reported facts, changes in the nuance of language will be considered to be sympathetic to the family context.
- 9.2.6 The formal recommendations will be endorsed by the statutory Safeguarding Partners before being included in the report.

## 10. Publication

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### 10.1 Publication

10.1.2 Publication is important to support local and national learning. Without publication learning is not shared and a key precept of the learning system is weakened.

10.1.3 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.<sup>14</sup> The fact that an individual or family might be identified by a determined investigator is not a reason not to publish.

### 10.2 Preparing for Publication

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

10.2.2 Where a LCSPR contains national recommendations or is likely to attract public and/or media attention, contact will be made with the National Panel in advance of formal publication to give the Panel the opportunity to consider the implications of proposed recommendations.

### 10.3 Managing the Impact of Publication

10.3.1 Consideration will be given to how best to manage the impact of publication on children, family members, practitioners and others closely affected by the case.

10.3.2 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.

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

### 10.4 Media Strategy

10.4.1 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.

### 10.5 Formal Publication

10.5.1 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](mailto:Mailbox.NationalReviewPanel@education.gov.uk)
- [SCR.SIN@ofsted.gov.uk](mailto:SCR.SIN@ofsted.gov.uk)

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<sup>14</sup> If they consider it inappropriate to publish the report, they must publish any information about the improvements that could be made following the review.

- [Mailbox.CPOD@education.gov.uk](mailto:Mailbox.CPOD@education.gov.uk)

10.5.2 Published reports will always include the name of the reviewer(s) and will be made available to read and download from the appropriate children's safeguarding website for the area. Reports will be publically available for **at least one year** and archived reports will be available on request from the Safeguarding Partners.

10.5.3 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](mailto:information@nspcc.org.uk)

## **11. Embedding Learning**

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### **11.1 Embedding Learning**

11.1.2 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.

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

11.2.1 The Review Team will consider at every meeting whether any immediate single or multi-agency action is required to respond to emerging issues identified through the review process<sup>15</sup>. They may wish to deliver swift messages to the workforce in specific agencies or disseminate multi-agency learning to a wider workforce. In so doing, the Review Team will consider what information is shared and whether this will have an impact on family members or any parallel investigations.

### **11.3 Disseminating and Sharing Learning from the Review**

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

11.3.2 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.

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

### **11.4 Monitoring Progress**

11.4.1 The local safeguarding arrangements will regularly audit progress on the implementation of recommended improvements and will regularly monitor and follow up actions to ensure improvement is sustained. A [Sample Action Plan Template \(Document 19\)](#) is included in the supporting documents.

### **11.5 Taking into Account Learning from National Reviews**

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

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<sup>15</sup> 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.'

## **12. Appendices and Supporting Documents**

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Appendix 1: Overview of Different Types of Learning Reviews

Appendix 2: Sample Confidentiality Agreement

Appendix 3: Example Genogram

### Supporting Documents

#### **Deciding whether to commission a Child Safeguarding Practice Review**

Document 1: Deciding whether to Notify

Document 1a: Referral Form

Document 2: Initial Scoping and Information Sharing Template

Document 2a: Template Letter – Request for Initial Scoping Information

Document 3: Sample Agenda for a Rapid Review Meeting

Document 4: Rapid Review Template

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

Document 6: Fact Sheet – Death of Care Leaver<sup>16</sup>

#### **Agreeing the Scope and Terms of Reference**

Document 7: Terms of Reference Template

#### **Engaging Children and Family Members**

Document 8: Template Letter – Informing Family Members of a Review

Document 9: Sample Leaflet – Local Child Safeguarding Practice Reviews

#### **Methodology**

Document 10: Sample Chronology Templates

Document 11: Template Letter – Request to complete a Chronology

Document 12: Guidance on Completing the Chronologies

Document 13: Learning Template

Document 14: Information Report Template

Document 15: Template Letter – Request to complete an Information Report

Document 15a: Guidance on Completing an Information Report

Document 16: Template Letter – Invitation to Reflective Learning Workshop

Document 17: Briefing Note on the role and purpose of Reflective Learning Workshops (to be sent as an appendix to Document 15)

Document 18: Sample Agenda for a Reflective Learning Workshop

Document 18a: Example Worksheets for a Reflective Learning Workshop

#### **The Report**

Document 19: Guidance on Drafting the Report

#### **Embedding Learning**

Document 20: Sample Action Plan Template

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<sup>16</sup> There is a requirement on the Local Authority to notify the National Panel of the deaths of care leavers up to their 25<sup>th</sup> birthday.

### Overview of Different Types of Learning Reviews

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

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

#### **Domestic Homicide Review**

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

#### **Safeguarding Adult Review**

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

#### **Multi-Agency Public Protection Arrangements – Serious Case Review**

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

#### **Child Death Review Arrangements**

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



## Sample Confidentiality Agreement for Rapid Review / Local Child Safeguarding Practice Reviews

In your role as a member of, or attendee at, one of the [insert Partnership name]'s Rapid Review or Local Child Safeguarding Practice Review meetings, you will have access to a variety of personal and business information which may be held in electronic format or in hard copy, or may be spoken in face-to-face or in telephone conversations. Much of this information is likely to be confidential in nature.

Confidential information may include:

- Personal information about identifiable persons, living or dead;
- Commercially sensitive information;
- Information about actions which have been proposed to the Partnership or Sub-Group, on which a decision has not yet been reached; and
- Information about the actions of an agency or agencies in the city.

Much of the business of the [insert name of Partnership] is of a sensitive nature and members and observers must guard against wrongful disclosure in the interests of children, young people and families and the reputation of the Partnership.

All information received in connection with the business of the Safeguarding Children Partnership is to be regarded as confidential, unless:

- It has been given to you with a clear instruction to discuss it with specified persons;
- It has been given to you as part of a consultation exercise, with a clear expectation that you will circulate it;
- It is an accepted decision that has been, or is to be, publicly announced; or
- It is already in the public domain (provided that this has not happened because of a breach of this agreement or of another duty of confidentiality).

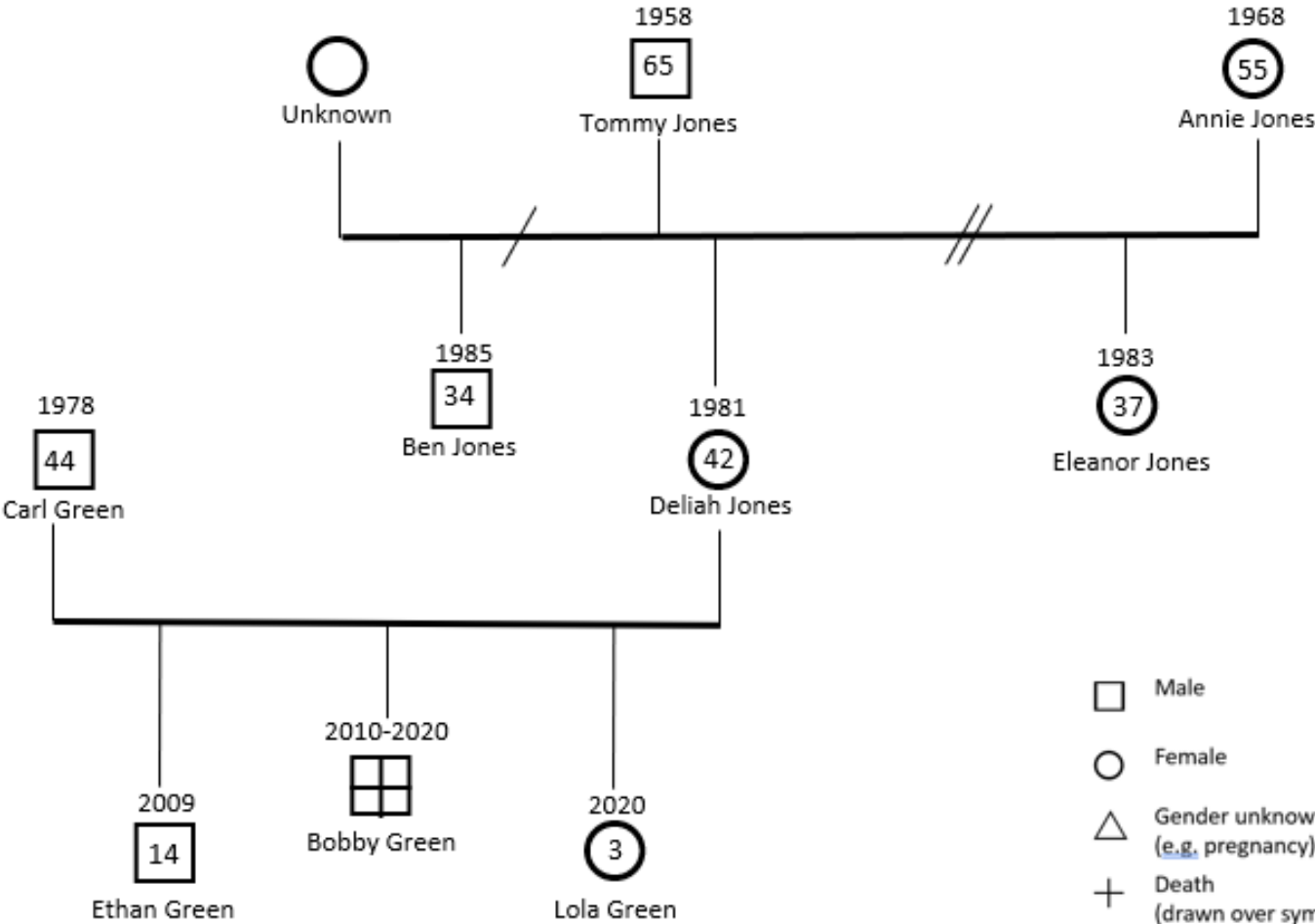
With the above exceptions, any information disclosed to you in the course of your duties must not be copied or disclosed to any third party without the prior agreement.

**I have read the above statement and agree that I will respect the confidentiality of information disclosed to me.**

NAME	<b><u>AGENCY AND FULL CONTACT DETAILS</u></b> (Postal address, telephone number and email.)	SIGNATURE
1.		

NAME	<b><u>AGENCY AND FULL CONTACT DETAILS</u></b> (Postal address, telephone number and email.)	SIGNATURE
2.		
3.		
4.		
5.		
6.		
7.		
8.		

### Example Genogram



### Genogram Key

- Male
- Female
- △ Gender unknown (e.g. pregnancy)
- + Death (drawn over symbol for gender)
- Enduring relationship (marriage or cohabitation)
- /□ Separation
- //□ Divorce

## Deciding whether to Notify

### Who should make a notification?

The duty to notify serious incidents to the National Panel sits with local authorities.

However, good practice suggests that the local authority should, wherever possible, consult with other Safeguarding Partners when deciding whether to notify.

### When should a notification be made?

A notification should be made if a ***child dies or is seriously harmed*** in the local authority area (or outside of England while they are normally resident in the local authority area) **AND** ***abuse or neglect is known or suspected***.

(Local authorities have a separate 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.)

### Advice from the National Panel

#### What constitutes abuse and neglect?

The National Panel interpret this as meaning there was sufficient reason to suspect that abuse or neglect was present and, at least in some way, caused or contributed to the death or serious harm.

If the event is in itself abusive, for example the child was murdered by a parent or carer, the Panel believes the criteria would have been met, regardless of whether or not there was pre-existing evidence of abuse or neglect.

Alternatively, the criteria would be met, if there is sufficient concern to trigger a strategy discussion, section 47 investigation, or care proceedings, or evidence to initiate a criminal investigation for possible abuse or neglect. The local authority does not need to wait until abuse or neglect is proven to make a notification and for a Rapid Review to commence.

#### Looked After Children

Local authorities are required to notify the Secretary of State and Ofsted when any looked after child died. While all such cases, including deaths by suicide, accidents and medical causes must be notified, unless abuse or neglect was known or suspected to have contributed directly to the death, these cases do not need a Rapid Review.

Where a looked after child has experienced recent abuse or neglect, or criminal or sexual exploitation, that is linked to the death or serious harm, then a Rapid Review should be undertaken.

#### Neglect

Working Together 2023 defines neglect as: *'The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.'*

In cases where incidents of neglectful care have resulted in death or serious harm, without any apparent evidence of this being a pattern of persistent failure to meet the child's needs,

consideration should be given as to whether the actions of the parent or carer were neglectful in and of themselves (in which case, neglect is suspected) and the outcome for the child has resulted in death or serious harm.

In other situations of neglect (or, indeed, other forms of maltreatment), there may be no single incident, but it is the cumulative effect of the neglect that is considered to meet the criteria of serious harm to the child. In such situations, the case should be notified as soon as the local authority or Safeguarding Partners become aware of the serious harm.

### **Sudden Unexpected Death in Infancy (SUDI)**

Most SUDI cases are appropriately reviewed through the child death review process and do not require a Rapid Review or LCSPR. Where abuse or neglect is considered to have directly contributed to the death (for example in cases of severe and persistent neglect with evidence of dangerous sleeping environments) then a Rapid Review should be undertaken.

Where an individual SUDI case reflects issues already explored in that national review – [Out of Routine](#) – the National Panel advises Safeguarding Partners carefully consider what additional local learning is likely to be achieved through an LCSPR.

### **Suicides**

Most suicides in young people are appropriately reviewed through the child death review process and do not require a Rapid Review or LCSPR. Where abuse or neglect is considered to have directly contributed to the death, then a Rapid Review should be undertaken.

### **Extrafamilial Harm**

When deciding whether to notify such cases of extrafamilial harm, and subsequently whether to undertake a Rapid Review or LCSPR, the National Panel suggests consideration is given to the following questions:

1. Is the death/serious harm caused by or directly related to actions or omissions of an adult with caring responsibilities for the child, or in a position of power or control in relation to the child?
2. Do the actions or omissions of any adult in relation to this child meet the definitions of either child sexual exploitation (CSE) or criminal exploitation?
3. Is the death/serious harm caused by or directly related to actions or omissions of an adult without any caring responsibilities for the child or in a position of power/control/trust in relation to the child, and without evidence of exploitation?
4. Is the death/serious harm caused by or directly related to actions or omissions of another child or young person without any evidence of any coercion or exploitation by an adult?

If the harm has been caused by an adult without caring responsibilities or in a position of power/control/trust, then that would typically constitute extra-familial violence rather than abuse or neglect. If the harm has been caused by another child, without any evidence of adult involvement or coercion, that would typically constitute child-on-child violence rather than being considered abuse or neglect.

In cases of extra-familial or child-on-child violence without any evidence or suspicion of exploitation or of coercion by adults, decisions on whether to notify and carry out a Rapid Review should be based on whether there are safeguarding concerns associated with the

case. In determining this, safeguarding partners should consider the ability of the parents or carers to provide a safe and nurturing environment for the child, the role of different agencies in supporting the child and family, whether the victim was known to children's services as well as the possible impact of multi-agency action or inaction. For example, risk assessments, school exclusion, failures to address known trauma. In any such cases, consideration should be given to the potential for meaningful learning around safeguarding in deciding whether to undertake an LCSPR.

One further consideration in cases of extra-familial harm is whether the death/serious harm was caused by or directly related to actions or omissions of an adult with caring responsibilities for the child, or in a position of power/control/trust in relation to the child within the context of a particular institution. In such cases, the safeguarding partners may wish to consider whether this constitutes institutional abuse or neglect

However, where the harm suffered was related to the quality of care provided in the institution, rather than being caused by or directly related to specific actions or omissions of an adult with caring responsibilities for the child, or in a position of power/control/trust in relation to the child within the institution, this may be a quality-of-care issue rather than institutional abuse or neglect. Key considerations here may be whether the harm was specifically targeted towards one or more children in the institution rather than simply being poor standards/quality of care that happened to affect that child, and whether the child/children in question were particularly vulnerable, for example those with learning disabilities or those known to be at risk of exploitation.

The National Panel published their national thematic review of child criminal exploitation, [\*It was hard to escape\*](#), in 2020. Safeguarding Partners should consider the learning from that review in their consideration of any cases of possible criminal exploitation.

Insert relevant area name and logo(s) here

## Referral for consideration for a Child Safeguarding Practice Review

### Criteria for Child Safeguarding Practice Reviews

Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected **and**
- the child has died or been seriously harmed

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child’s mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health<sup>17</sup>. **Any individual or organisation working with children should inform the relevant Safeguarding Partners<sup>18</sup> of any incident they think should be considered for a Child Safeguarding Practice Review using this form.**

Professionals should discuss the case with their agency’s designated safeguarding lead/officer to help formulate the rationale. If you need advice completing this form please contact us: our phone and email address are included at the end of this form. **A referral should be made as soon as possible after the serious incident occurs.**

### Background Information

Name of Child:

Date of Referral:

### Agency Referral<sup>19</sup>

NAME	AGENCY & DESIGNATION/TITLE	CONTACT DETAILS – Address, telephone number and e-mail address

<sup>17</sup> Child perpetrators may also be the subject of a review, if the definition of ‘serious child safeguarding case’ is met.

<sup>18</sup> The formal Safeguarding Partners are the CCG, police and the local authority. Details of where to send this form are included at the end of the form.

<sup>19</sup> Please note that, as the referrer, you may be required to present the referral at the local Child Safeguarding Practice Review Group.

Please give the details of the designated safeguarding lead/officer with whom you have discussed the case.

NAME	AGENCY & DESIGNATION/TITLE	CONTACT DETAILS – Address, telephone number and e-mail address

## Section 1: Brief Overview of Child and Family Composition

### 1.1 Child's Details

Name of Child	
Date of Birth & Age	
NHS Number (if known)	
Home Address	
Gender	
Ethnic Origin	
Faith/Religion	
Disability	
Is the child/young person looked after?	
Is the child/young person currently subject to a child protection plan, or have they been previously? (If so when, for what and for how long?)	
Is the child/young person open to Children's Social Care or a Children & Families Practice (if so, who is the lead practitioner)?	
Date of Death or Serious Incident (please specify which)	
Address of location of incident	
Carer at time of incident	
Is this case known to be the subject of a criminal investigation? (If so, who is the lead investigator?)	



Is this case known to be the subject of a Coroner’s Inquiry? (If so, who is the key contact?)	
Are there any adult safeguarding concerns and have these been shared via an Adult referral form? (If so, who is the key contact?)	

**1.2 Details of Family Members and any Significant Others**

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

<b>What action has been undertaken to safeguard and protect any siblings of the child who is the subject of this referral?</b>

**1.3 Other Agencies Known to be Involved**

Agency	Contact Details: Address, Telephone and E-mail	Reason for involvement (include whether current or not)

**Section 2: Case Background**

*PLEASE NOTE: The information you provide will be used to help establish whether the case meets the criteria for a Child Safeguarding Practice Review or other type of learning review.*

<b>Please provide a brief outline of the child and family circumstances and the incident that triggered this referral:</b>

<b>Please outline why you are making this referral. What areas of practice are you concerned about? Have you identified any immediate learning?</b>

***Please use the chronology table below to outline any events around the time of the incident.***

*PLEASE NOTE: This should only include key events and DOES NOT need to be a detailed chronology at this stage.*

Date and Time	Event

**Please add any additional information you think may be relevant and may assist decision-making:**

***NOTE: THE ABOVE SHOULD FOLLOW A DISCUSSION WITH A NOMINATED MANAGER OR SAFEGUARDING LEAD / OFFICER IN YOUR AGENCY.***

**Section 3: Advice and Submission of this Form**

Insert here the contact details of those who can provide advice on the completion of this form and also the details of the email address to which the form should be submitted.

***A multi-agency Rapid Review of your referral will be undertaken and you will be informed of the outcome.***

Insert relevant area name and logo(s) here

## Initial Scoping and Information Sharing

### Potential Child Safeguarding Practice Review

Chapter 4 of *Working Together 2023* provides clear criteria about when Child Safeguarding Practice Reviews should be conducted (see section 1.4 of the Regional Guidance). We have received notification of a serious incident which may meet the criteria for a Child Safeguarding Practice Review and will, therefore, be holding a Rapid Review to consider the case.

To inform the Rapid Review meeting, we need to gather the basic facts about the case and determine the extent of agency involvement with the child and family. This will help the Safeguarding Partners decide whether to progress a formal Child Safeguarding Practice Review and to determine the most appropriate method to identify and cascade learning from this case.

We are required to hold the Rapid Review meeting and agree the way forward within timescales outlined in national guidance (currently within 15 working days). This initial scoping and information sharing form should, therefore, be returned to us **within 5 working days**.

### Contact Details of Individual / Agency Completing this Form

NAME	AGENCY & DESIGNATION/TITLE	CONTACT DETAILS – Address, telephone number and e-mail address

**Date Completed:**

### Background Information

<b>Summary of Case:</b>
<b>Indicative time period to be looked at:</b> <i>(Good practice suggests that the time period examined should be limited. However, please include information from outside this time period if you feel it is relevant to the case.)</i>

### Section 1: Composition of the Child’s Family

*This should be completed BEFORE the form is sent out. All agencies are asked to check whether the details below match information held on their systems. Please advise of any anomalies.*

<p><b>SUBJECT CHILD:</b>  <b>Also Known As:</b>  <b>Ethnicity:</b>  <b>National Health Number:</b>  <b>D.O.B:</b>  <b>Date of Serious Injury:</b>  <b>Home Address:</b>  <b>Previous Addresses:</b></p>	
<p><b>MOTHER:</b>  <b>Also Known As:</b>  <b>Ethnicity:</b>  <b>National Health Number:</b>  <b>D.O.B.:</b>  <b>Home Address:</b>  <b>Previous Addresses:</b></p>	
<p><b>FATHER:</b>  <b>Also Known As:</b>  <b>Ethnicity:</b>  <b>National Health Number:</b>  <b>D.O.B.:</b>  <b>Home Address:</b>  <b>Previous Addresses:</b></p>	
<p><b>SIBLING:</b>  <b>Also Known As:</b>  <b>Ethnicity:</b>  <b>National Health Number:</b>  <b>D.O.B.:</b>  <b>Home Address:</b>  <b>Previous Addresses:</b></p>	
<p><b>SIGNIFICANT ADULTS / OTHERS:</b>  <b>D.O.B.:</b>  <b>National Health Number:</b>  <b>Ethnicity:</b>  <b>Home Address:</b></p>	

**Section 2: Agency Information and Involvement**

**1. Provide a brief summary of your agency’s involvement with the subject child AND the individuals listed in the family composition. (Please focus on the key significant events in chronological order and, where appropriate, include the date of commencement and completion of service).**

**2. From your agency’s records are you able to confirm the following information for the individuals listed below:**

*This should be completed BEFORE the form is sent out – include names only in the first box of all the individuals listed in ‘Section 1 – Composition of the child’s family’.*

**Ethnicity:**


**Language:**


**Religion or other belief system:**


**Employment status:**


**3. Brief analysis of individual and multi-agency practice. (Please identify any outstanding practice or potential learning).**

**4. Please identify any areas for concern as to the way in which partners have worked together to safeguard the subject child.**

**5. Have you identified any learning and what action have you taken to implement this learning?**

Please complete the action tracker template below. Please feel free to extend the table as necessary if more learning points are identified.

	Learning Point	Action Required	Lead	Target date for completion	Evidence of Progress of Implementation	RAG
1						
2						
3						
4						
5						

**6. Are you aware of the involvement of any other agencies? If yes, please give details.**

**7. Please include any further relevant information that you wish to bring to the attention of the Rapid Review meeting.**

**Section 3: Advice and Submission of this Form**

**For advice on completion of this form contact:**

Insert here the contact details of those who can provide advice on the completion of this form and also the details of the email address to which the form should be submitted

**Please submit completed form to:**

***A multi-agency Rapid Review will be undertaken and you will be informed of the outcome.***

Insert relevant area logo(s) and address here

Date: **[insert date]**

Dear Safeguarding Leads,

**Child Safeguarding Practice Review – Initial Scoping and Information Sharing**

We have received notification of a serious incident which may meet the criteria for a Child Safeguarding Practice Review. We will, therefore, be holding a Rapid Review to consider the case.

To inform the Rapid Review meeting, we need to gather the basic facts about the case and determine the extent of agency involvement with the child and/or any family members. This will help the Safeguarding Partners decide whether to undertake a formal Child Safeguarding Practice Review and to determine the most appropriate method to identify and cascade learning from this case.

We are initially asking agencies to:

1. Clarify whether your organisation had any involvement with the subject child and/or named individuals within the family composition outlined in Section 1 of the attached form.
2. Complete the attached *Initial Scoping and Information Sharing* form if you have had any involvement with the subject child or a member of their family.
3. Secure all records/files in relation to this case, ensuring that they are removed to a secure place where they are not accessible to agency personnel other than through you or your nominated representatives.
4. Keep your agency's submission in relation to this case separate from the case records/files.

If the child or family is not known to your organisation, please confirm this in writing.

We are required to hold the Rapid Review meeting and agree the way forward within timescales outlined in national guidance (currently within 15 working days). This *Initial Scoping and Information Sharing Form* should, therefore, be returned to us at the address included on the form **within 5 working days**. In this case this will be **[insert submission date]**.

If you require any further information please contact **[insert contact name and phone number]**.

Yours sincerely,

**Add appropriate signature for area**

Enc: Initial Scoping and Information Sharing Form



## AGENDA

### RAPID REVIEW – (Insert Child’s Initials)

Date:

Time:

Venue

Agenda Items	Lead	Time
<b>Rapid Review Chair:</b>		
<b>Business Support:</b>		
1.	Welcome/introductions/apologies	
2.	Overview of incident	
3.	Confirmation of family details	
4.	Agency reports	
5.	Confirmation of immediate safeguarding actions/evidence of historic or current domestic abuse	
6.	Decision Summary and Rapid Review Panel recommendation for National Panel	
7.	AOB	

Insert relevant area name and logo(s) here

## Rapid Review

### Criteria for Child Safeguarding Practice Reviews

Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected **and**
- the child has died or been seriously harmed

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child’s mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health<sup>20</sup>.

### Purpose of the Rapid Review

In line with *Working Together 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 there is any immediate action needed to ensure children’s safety and share any learning appropriately;
- consider the potential for identifying improvements to safeguard and promote the welfare of children;
- decide what steps to take next, including whether or not to undertake a child safeguarding practice review.

### Background Information

**Name of Child:**

**Date of Birth and Age:**

**Ethnicity:**

**Gender:**

**Other key details about the child (e.g., any disability, LAC, faith/religion etc.):**

**Date of Death / Serious Incident:**

**Date notified to Ofsted:**

**Date of Rapid Review:**

*(Ideally this should be a face to face meeting but may be a telephone conference if constrained by time)*

**List of Participants in Rapid Review:**

*(To be quorate at least one representative from each of the safeguarding partners needs to be present – i.e. a representative from the ICB, Police and Local Authority)*

Name	Role/Title	Agency/Organisation

<sup>20</sup> Child perpetrators may also be the subject of a review if the definition of ‘serious child safeguarding case’ is met.


Observers		

**Omissions to the list of participants:** *(Please explain the reason for the omission of any agency whose involvement would normally be expected)*

**Section 1: Case Background**

*This should be completed in advance of the Rapid Review meeting.*

**Details of Family Members and Significant Others**

*All siblings should be included as well as parents and any significant adults. A family tree (genogram) may be helpful: see example in Appendix 3.*

Name and Address	Relationship to Child	Date of Birth	Ethnicity	Other relevant information (e.g. legal status, known physical or mental health problems, disabilities)

**Case Summary**

**Please provide a concise outline of the child and family circumstances and the incident that triggered this rapid review. Include any other relevant context.**

**Documentation available to this Rapid Review:**

*This should list the documentation referred to when undertaking the Rapid Review. DO NOT embed these documents.*

**Section 2: Consideration of Case, Criteria and Guidance**

*This should be completed during the meeting and agreed by participants.*

**2.1 Immediate Safeguarding Arrangements of any children involved**

Has ALL appropriate immediate action been taken to ensure children’s safety and share any learning appropriately?

Yes  No

**Please give details of action taken. If no, what actions need to be taken? When will these be taken and by whom?**

## 2.2 Identifying Improvements to Safeguard and Promote the Welfare of Children

Those present at the Rapid Review have considered whether to carry out a local child safeguarding practice review and have agreed that the case has the potential to meet the following criteria *from Working Together 2023*:

*Tick all that are relevant. These should be agreed by all participants in the Rapid Review.*

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children
- is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate
- safeguarding partners have cause for concern about the actions of a single agency
- there has been no agency involvement and this gives the safeguarding partners cause for concern
- more than one local authority, police area or Integrated Care Board is involved, including in cases where families have moved around
- the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings
- None of the above

## 2.3 Rapid Review Discussions

**The Rapid Review should clarify the nature of harm suffered and whether it meets the criteria for serious harm and/or long-term impairment of health. Please summarise the key Practice Learning Events discussed in the Rapid Review, including the case analysis against the criteria for a child safeguarding practice review and any insights into the ‘why’ questions (see section 1.2.1 and 4.6.3 of the guidance).**

**Ensure you have considered the issues listed in section 4.6.4 of this guidance.**

***Time period:***

***Previous agency involvement with [insert name of significant family members]:***

***What was the child's lived experience:***

***Rapid Review discussion:***

***Update from Police:***

***Long term impact of injuries sustained:***

***Exploration of key themes / contextual factors:***

***Any relevant national reviews that can be referenced and used to support local learning (The National Panel's 'Rapid Review Examples' provide some useful examples of how to do this: see link in section 4.6.7):***

***Good Practice identified:***

***Rapid Review Conclusion:***

**The Rapid Review is likely to identify immediate learning that can be acted upon. Please summarise here, including whether it is single or multi-agency learning. Include how learning will be shared and implemented.**

**Has legal advice been sought?** *If yes, please give details.*

**Section 3: Recommendation**

After completing this Rapid Review, it has been agreed that this case:

- a) Meets the criteria for a national Child Safeguarding Practice Review
- b) Meets the criteria for a Local Child Safeguarding Practice Review
- c) Does not meet the criteria but warrants a Local Child Safeguarding Practice Review
- d) Warrants consideration of DHR, SAR, MAPPA or other   
Please state: \_\_\_\_\_
  
- e) The Rapid Review has identified learning that has been acted upon, obviating the need for further review

**Proposed Key Lines of Enquiry for LCSPR (if decision is to progress to a review)**

**Reasons for Recommendation, including the potential identified for additional learning.** If the decision is not to proceed, please explain why it is thought there is no further learning to be gained. If the decision is not to proceed because the Rapid Review has identified all potential learning, please ensure that the section on learning above is sufficiently detailed and reference this learning here.

**Sign off:**

*Please add one or two sentences that explain how the Rapid Review has been formally ratified by the three Safeguarding Partners. This should include who from each of the three Safeguarding Partners is taking executive responsibility for the decision-making in the Rapid Review.*

**Date this form submitted to the National Panel:**

*If you have an Independent Chair or Scrutineer you may wish to ask them to endorse this form.*



Insert relevant area logo(s) and address here

Date: [insert date]

Child Safeguarding Practice Review Panel  
Sanctuary Buildings  
20 Great Smith Street  
London  
SW1P 3BT

Dear [Insert name of current Panel Chair],

**Decision of the Rapid Review of [insert case name / reference]**

I am writing to you in your capacity as Chair of the Child Safeguarding Practice Review Panel. Our Safeguarding Partners received notification of a serious incident which may meet the criteria for a child safeguarding practice review on [insert date] and have, therefore, undertaken a Rapid Review to consider the case.

This Rapid Review included a representative from each of the Safeguarding Partners and concluded that the case **meets the criteria for a national Child Safeguarding Practice Review / meets the criteria for a local Child Safeguarding Practice Review / does not meet the criteria for a Child Safeguarding Practice Review.** [Delete as appropriate and then turn the related text black and delete this instruction.]

I attach for your information a copy of our completed Rapid Review which provides a summary of the case and the decision and rationale of the Safeguarding Partners. [The decision has been endorsed by INSERT NAMES of the partnership's Delegated Safeguarding Partners/Independent Scrutineer].

I trust this is sufficient information for you to share with the Panel. However, please do not hesitate to contact me [or insert contact details of any relevant individual] if you require any further information.

Yours sincerely,

Add appropriate signature for area.

Enc: Rapid Review Template

## **FACTSHEET – Death of a Care Leaver**

From January 2024 local authorities **should** notify the Secretary of State for Education and Ofsted of the death of a care leaver aged up to their 25th birthday as per the revisions to Working Together to Safeguard Children.

### **Why should local authorities notify the death of a Care Leaver**

Notifications for care leaver deaths will allow the Department for Education to understand and learn more about what happened so we can make better informed policy decisions to prevent future deaths.

### **How should local authorities notify the death of a Care Leaver**

The notification should be made in the same way as for a Child Serious Incident Notification, via the [Child safeguarding incident notification system](#) when a care leaver is aged;

- **under 18** years of age, notifications should be made by selecting death of 'Looked after child / Care leaver child (under 18 years old)'. Please continue to select 'abuse' and/or 'neglect' or 'no abuse or neglect'. There will be an option on the 'child detail' page to identify the child as a care leaver.
- **18 years old up to their 25<sup>th</sup> birthday**, notifications should be made by selecting death of 'Care Leaver 18 years old up to 25th birthday'.

The information requested for the death of a care leaver is less than for a child serious incident notification.

The Child Safeguarding Practice Review Panel will receive the notification but will not review as their remit is children's serious incidents up to and including children age 17. The notification of the death of a care leaver will not itself necessitate a rapid review or local child safeguarding practice review. Ofsted will also be notified of the death of a care leaver through the notification system.

### **When to make a notification:**

1. Local authorities have a **duty** to notify where a child dies or is seriously harmed, and abuse or neglect is known or suspected. This includes children that are looked after and care leavers up to and including the age of 17 years.
2. Local authorities have a **duty** to notify the death of a looked-after child regardless of abuse or neglect being present.
3. Local authorities **should** notify the death of a care leaver for those aged up to their 25<sup>th</sup> birthday, where it is aware of their care leaver status, regardless of abuse or neglect being present.

### **Definitions**

#### Child

A 'child' is anyone aged under 18.

#### Looked after child

A child is looked-after by a local authority if he or she falls into one of the following:

- is provided with accommodation, for a continuous period of more than 24 hours
- is subject to a care order
- is subject to a placement order

### Care leaver

A care leaver is anyone aged up to their 25<sup>th</sup> birthday<sup>1</sup> and meets both of the following criteria:

- is no longer looked-after
- has been looked after for at least 13 weeks which began after they reached the age of 14 and ended after they reached the age of 16.

Care leavers are entitled to support from their Personal Adviser up to their 25th birthday. Local authorities are required to keep in touch with all care leavers up the point they reach age 21; and to make their best efforts to contact all care leavers aged 21 to 24 annually to remind them that they remain eligible for support.

If a young person chooses not to take up support between 21-24 years of age, we understand that the local authority might no longer be aware of a care leaver's whereabouts or circumstances (and therefore their death). This is why the requirement for a notification is not mandatory.

### **Collecting Serious Incident Notification Data**

It is important that all serious incidents that meet the criteria as outlined in Working Together to Safeguard Children are notified, including those for the death of a care leaver. By submitting a notification, it will ensure that relevant learning from incidents is identified and fed back into the system to prevent future harm or death.

### **Support or Guidance**

For further support or guidance please go to:

- [Working together to safeguard children - GOV.UK \(www.gov.uk\)](https://www.gov.uk)
- [Child Safeguarding Practice Review Panel guidance for safeguarding partners \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)
- [Children Act 1989: transition to adulthood for care leavers - GOV.UK \(www.gov.uk\)](https://www.gov.uk)
- [Extending Personal Adviser support to age 25 - GOV.UK \(www.gov.uk\)](https://www.gov.uk)

Insert relevant area logo(s) and address here

## Local Child Safeguarding Practice Review Terms of Reference

<b>CHILD REFERENCE:</b>	
<b>DATE:</b>	

<b>1. INTRODUCTION</b>
------------------------

The aim of this review is to identify improvements that can be made to better safeguard children and to prevent, or reduce the risk, of recurrence of similar incidents.

The review will undertake a rigorous and objective analysis of what happened and why. It will consider whether there are systematic issues, and whether and how policy and practice need to change.

It should be noted that the review is not being conducted to hold individuals, organisations or agencies to account as there are separate processes for this.

<b>2. CASE SUMMARY</b>
------------------------

**Summary of Serious Incident:**

**Information about the Family:**

<b>3. REVIEW TEAM</b>
-----------------------

**Name of Lead Reviewer:**

**Membership of the Review Team:**

*The names of the Review Team members and the organisation they represent should be included here along with details of any specific responsibilities of these members (such as the Police representative liaising with the Senior Investigating Officer and Crown Prosecution Services where there are parallel investigations).*

<b>1. SCOPE OF THE REVIEW</b>
-------------------------------

	<p><b>Time Period to be Considered by the Review and Rationale:</b></p> <p><b>Key Issues to be Addressed by the Review:</b>          (NOTE: These may evolve as more information becomes available during the review. In line with the Regional Guidance, these will need to consider the 'why' questions.)</p>
2.	PLANS TO INVOLVE CHILDREN AND FAMILY MEMBERS
	<p><b>NOTE:</b> Plans to engage children and family members will need to take into account the legal considerations outlined in Section 4 below.</p> <p>This section should describe the agreed plans to involve children and family members and who will be responsible for making contact / following up.</p>
3.	METHODOLOGY
	<p><b>NOTE:</b> The headings below are based on the tools described in the Regional Toolkit and Practice Guidance. Each case will be examined individually and an appropriate methodology agreed. The headings should, therefore, be altered or deleted depending on the methodology used.</p> <p><b>Chronologies:</b></p> <p><b>Learning Template / Information Report:</b></p> <p><b>Reflective Learning Workshop / Feedback Session:</b></p>
4.	LEGAL CONSIDERATIONS
	<p><b>Parallel Investigations:</b></p> <p><b>Legal Advice:</b></p>

5.	<b>OTHER CONSIDERATIONS</b>
	<p><i>NOTE: The other factors that will need to be considered will vary from case to case. However, as a minimum, it will be important to identify whether there are any racial, cultural, linguistic issues that need to be considered or issues related to the religious background of the child or members of their family.</i></p>
6.	<b>TIMELINE AND KEY DATES</b>
	<p><i>This section should include key milestone dates agreed for the review, including the target date for the presentation of the learning to the Safeguarding Partners.</i></p>

Insert relevant area logo(s) here

Date: [insert date]

Dear [insert name],

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 sad case, 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

Insert relevant logo(s) here

**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

Insert relevant logo(s) here

# **Child Safeguarding Practice Reviews**

## **Information for Parents and Carers**



## **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 death or injuries happening in the future.

To do this they usually undertake a Child Safeguarding Practice Review. This examines 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.

Whilst we recognise your grief and anxiety, we believe that the circumstances relating to your child mean that a Child Safeguarding Practice Review should be carried out.

## **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 or Children's Trust.

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 are aware that this is a very difficult time for you but we want to learn all we can for the future.

We believe it is very important that family members share their experience of services and tell us whether anything could have been done better. 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, the Lead Reviewer will arrange to meet with you to share the key 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 the Lead Reviewer 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 needs to be extended.

## **Publication of the report**

The report will not contain any identifying details of your child or family. It will then be published on the internet.

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



Insert relevant area logo(s) and address here

Date: [insert date]

Dear Safeguarding Lead,

### **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:

1. A brief 'Case Summary' (this includes an outline of the incident, the family composition, the time period that is the focus of the review and key questions);
2. 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

## Case Summary

*This document should be completed by the manager/administrator of the local Child Safeguarding Practice Review prior to being sent to agencies. It is designed to provide essential reference information to individual agencies when completing their Chronologies and/or Information Report.*

This document should be used as a reference when completing the individual agency chronologies and the Information Report.

### Background to the Case:

*Include here a background summary of the child's death / serious injury.*

### Child's Details:

Name:

D.O.B:

D.O.D/Serious injury:

Address:

### Family Composition:

*Additional family members (e.g. grandparents where they are key carers) may need to be added to the table before it is sent out.*

	NAME	D.O.B	ADDRESS
MOTHER			
FATHER			
SIBLING			
SIBLING			

### Time Period:

The time period covered by the review has been selected to reflect the potential learning likely to be achieved. (There is little value in identifying weaknesses in professional practice or procedures that have already changed). Please focus on this time period when completing your Chronologies and Information Report. **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.**

*Include here time period from the terms of reference*

**Key Lines of Inquiry:**

*Include here the Key Lines of Inquiry from the Terms of Reference*

**Agency Specific Issues:**

*Include here any agency specific issues that should be considered when completing the Information Report*

## 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 Officer within the agency should **quality assure and sign off the chronology** prior to its submission.

Further advice and support is available from [\[insert contact details of individual able to provide advice and support\]](#).

## 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 often 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. (This will often be colour coded to facilitate an 'at a glance' overview of agency involvement.)

### 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 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.



**NOTE: 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.

## Child Safeguarding Practice Review

### Learning Template

#### GUIDANCE FOR COMPLETION

1. Section 1	<i>This should only be completed once at the beginning of the document</i>
2. Agency	<i>If agencies have provided multiple services to the child / family all the provision should be merged into one learning document.</i>
3. Author Including Designation and Contact Details	<i>The author should be independent of the case and have sufficient authority and competency within the agency they are representing to critically appraise safeguarding practice.</i>
4. Senior Agency Lead Including Designation and Contact Details	<i>The single agency learning summary should be signed off by the organisation at an executive level.</i>
5. Section 2	<i>This should include a brief synopsis of agency involvement with the subject child and their family, relevant to the Terms of Reference, prior to the review period</i>
6. Section 3	<i>This should be completed for each theme or key line of enquiry.</i>
7. Section 4	<i>This should be completed for each significant event that falls outside the of the key lines of enquiry.</i>
8. Significant Practice Event / Issue / Key Line of Enquiry:	<i>Individual agencies should review their own service delivery and complete a section 3 or 4 for each identified issue, event or Key Lines of Enquiry (KLOE). Include here the narrative of the issue/event or KLOE include date or timespan when indicated. <b>NB If the author considers they have uncovered a significant area of learning not currently covered in the Terms of Reference they should alert their panel representative as soon as possible</b></i>
9. Section 5	<i>This should include a brief synopsis of agency actions relating to the subject child and their family post review period.</i>
10. Analysis	<i>Your analysis of safeguarding practice is crucial.... This could include;</i> <ul style="list-style-type: none"> <li>• <i>at the time' reflection and expectations of practice.</i></li> </ul>

	<ul style="list-style-type: none"> <li>• <i>provide context where relevant e.g. resource/staffing issues/handovers, learning opportunities/deficits, relevant policies, procedures, protocols and operating frameworks, national context</i></li> <li>• <i>management oversight and strategic monitoring arrangements</i></li> <li>• <i>areas for development and improvements made to practice following the event/issue/KLOE.</i></li> <li>• <i>Consideration of areas still requiring action/improvement.</i></li> <li>• <i>multiagency partnership working arrangements.</i></li> <li>• <i>effectiveness of cross boundary arrangements.</i></li> <li>• <i>evidence and research base.</i></li> </ul>
<b>11. Recommendation</b>	<i>Recommendations are specific and overarching. Normally action points fall out of the recommendations</i>
<b>12. Highlight Good Practice</b>	<i>Remember to pull out good practice and what worked well</i>

**SECTION 1:**

<b>1. SUBJECT CHILD DETAILS</b>	
<b>2. AGENCY</b>	
<b>3. AUTHOR</b> <b>(Including Designation and Contact Details)</b>	
<b>4. SENIOR AGENCY LEAD</b> <b>(Including Designation and Contact Details)</b>	
<b>5. DATE OF COMPLETION:</b>	

**SECTION 2:**

<p><b>SYNOPSIS OF AGENCY INVOLVEMENT <u>PRIOR</u> TO THE REVIEW PERIOD AND ADDITIONAL LEARNING:</b></p> <p>(Review period: <b>(ADD Dates)</b>)</p>	
--	--

**SECTION 3:**

<p><b>SIGNIFICANT PRACTICE EVENT / ISSUE / KEY LINE OF ENQUIRY 1:</b></p>	
<p><b>ANALYSIS:</b></p>	
<p><b>RECOMMENDATION:</b></p>	
<p><b>HIGHLIGHT GOOD PRACTICE:</b></p>	

<p><b>SIGNIFICANT PRACTICE EVENT / ISSUE / KEY LINE OF ENQUIRY 2:</b></p>	
<p><b>ANALYSIS:</b></p>	
<p><b>RECOMMENDATION:</b></p>	
<p><b>HIGHLIGHT GOOD PRACTICE:</b></p>	

<b>SIGNIFICANT PRACTICE EVENT / ISSUE / KEY LINE OF ENQUIRY 3:</b>	
<b>ANALYSIS:</b>	
<b>RECOMMENDATION:</b>	
<b>HIGHLIGHT GOOD PRACTICE:</b>	

<b>SIGNIFICANT PRACTICE EVENT / ISSUE / KEY LINE OF ENQUIRY 4:</b>	
<b>ANALYSIS:</b>	
<b>RECOMMENDATION:</b>	
<b>HIGHLIGHT GOOD PRACTICE:</b>	

<b>SIGNIFICANT PRACTICE EVENT / ISSUE / KEY LINE OF ENQUIRY 5:</b>	
<b>ANALYSIS:</b>	
<b>RECOMMENDATION:</b>	
<b>HIGHLIGHT GOOD PRACTICE:</b>	

<b>SIGNIFICANT PRACTICE EVENT / ISSUE / KEY LINE OF ENQUIRY 6:</b>	
<b>ANALYSIS:</b>	
<b>RECOMMENDATION:</b>	
<b>HIGHLIGHT GOOD PRACTICE:</b>	

<b>SIGNIFICANT PRACTICE EVENT / ISSUE / KEY LINE OF ENQUIRY 7:</b>	
<b>ANALYSIS:</b>	
<b>RECOMMENDATION:</b>	
<b>HIGHLIGHT GOOD PRACTICE:</b>	

**SECTION 4**

<b>SINGLE AGENCY SIGNIFICANT PRACTICE EVENT / ISSUE:</b>	
<b>ANALYSIS:</b>	
<b>RECOMMENDATION:</b>	
<b>HIGHLIGHT GOOD PRACTICE:</b>	

**SECTION 5**

<b>SYNOPSIS OF AGENCY INVOLVEMENT POST THE REVIEW PERIOD AND ADDITIONAL LEARNING</b>	
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Insert relevant area name and logo(s) here

## Information Report

### Purpose of this Information Report

When a Local Child Safeguarding Practice Review is commissioned, relevant agencies may be asked to complete an Information Report, along with chronologies of their agency's involvement in the case and any organisational changes that took place within the time period being examined. The Information Report is designed to analyse the agency's involvement with the child and family and any themes that have emerged. The aim is to:

- allow agencies to look openly and critically at individual and organisational practice, and the context within which people were working;
- describe actions that have already been taken;
- identify examples of good practice in agencies;
- identify any potential learning for the agency or for multi-agency arrangements.

Information Reports are not part of any disciplinary inquiry or process relating to individual practitioners. Any disciplinary action should be conducted in line with individual agencies' established procedures and should be undertaken separately from the review.

### Disclosure of Information Reports

Agencies should be aware that a request may be made by the police or court for disclosure of chronologies or Information Reports 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.

### Quality Assurance and Agency Sign Off

Information Reports must be endorsed by a Senior Manager before being submitted.

**Before completing this form**, it is essential that you read both the attached 'Case Summary' and the 'Guidance Notes on Completing an Information Report'. You should regularly refer to both these documents when completing this form.

In particular, please ensure that you **specifically address the identified 'Key Lines of Enquiry' and the 'Agency Specific Issues'** that are outlined on the Case Summary document.

---

### Background Information

**Name of Child / Case Reference:**

**Name of Agency Completing this Form:**



*NOTE: To maintain independence, neither the individual completing this report nor the Senior Officer endorsing it should have had any direct involvement in this case.*

**Contact Details of Individual Completing this Form**

NAME	AGENCY & DESIGNATION/TITLE	CONTACT DETAILS – Address, telephone number and e-mail address

**Date form completed:**

**Contact Details of Senior Officer Endorsing this Form**

NAME	AGENCY & DESIGNATION/TITLE	CONTACT DETAILS – Address, telephone number and e-mail address

**Date Information Report endorsed by agency senior officer:**

I confirm that the individual completing this report has had no previous operational involvement in the management of this case.

**Section 1: Sources of Evidence and Agency Understanding of the Case**

**1. Parallel Processes and Investigations**

Is your organisation undertaking an internal, multi-agency or parallel review process related to this case (such as misconduct hearing, serious untoward incident, Independent Police Complaints Investigation etc.)?

Yes  No

<p><b>If yes, please state the type of investigation and, where relevant, give the name and contact detail of the individual leading or co-ordinating the investigation.</b></p>
<p></p>

**2. Sources of Information**

*Before completing this section, please refer to the advice in the 'Guidance Notes on Completing an Information Report'.*

**Please give the date that files were secured and by whom:**

**Please list the documents that were reviewed in putting together this report:**  
*(An explanation should be included of any documents not seen and the reason why).*

**Give details of interviews undertaken:**

**3. Summary of Agency involvement with the child and family who are the subject of this review**

3.1 Please tick to confirm you have reviewed the details of the victim, perpetrator, family and significant others in the attached 'Case Summary':

Yes

**Please include any corrections and additional information your agency has on the victim, perpetrator, family or significant others involved in this case:**

**3.2 Please include any contextual information relevant to this case that has not be captured elsewhere**

*(This may include information about the agency’s involvement with the victim, perpetrator, family member or any significant others or information about organisational factors that may have influenced events).*

**Section 2: Analysis of Involvement**

**4. Analysis of Involvement**

*Before completing this section, please refer to the questions in the ‘Guidance Notes on Completing an Information Report’. In your answer you must:*

- *report why actions did or did not take place;*
- *consider the events that occurred, the decisions made, and the actions taken or not and assess practice against guidance and relevant legislation;*
- *address the ‘Key Lines of Enquiry’ and ‘Agency Specific Issues’ outlined in the attached Case Summary;*
- *complete analysis in respect of key critical factors, which are not otherwise covered by the prompts above.*



**8. Multi-Agency Learning**

- *What actions to improve multi-agency working do you wish the Review Team to consider as a result of this case?*

**Section 4: Other Relevant Information**

**9. Please include any other relevant information that you wish to bring to the attention of the Independent Lead Reviewer / Review Team**

**Section 5: Advice and Submission of this Form**

**Insert here the contact details of those who can provide advice on the completion of this form and also the details of the email address to which the form should be submitted.**

***The Independent Lead Reviewer and other members of the Review Team will evaluate each Information Report as part of the process of identifying learning from this case. You will be notified of any discrepancies and may be requested to provide further information, either in writing or by attending a meeting.***

Insert relevant area logo(s) and address here

Date: [insert date]

Dear Safeguarding Lead,

### **Request to Complete an Information Report**

We are undertaking a local Child Safeguarding Practice Review into the **tragic death / serious injury** of [insert name of child(ren)]. To support this, we are asking agencies to examine their involvement with [insert name of child(ren)] and their family in order to analyse individual and organisational practice, consider any single or multi-agency learning, and identify good practice.

I would, therefore, be grateful if you could arrange for completion of the attached Information Report template. To support completion, I attach two reference documents:

1. A brief 'Case Summary' (this includes an outline of the incident, the family composition, the time period that is the focus of the review and key questions);
2. Guidance on completing the Information Report.

### 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 **frontline workers and supervisors who had direct involvement with the child and / or their family**. I would, therefore, also ask you to confirm the name and contact details of all relevant staff in your organisation. Your agency may have previously submitted these names along with a completed chronology but it is worth considering whether any additional individuals are identified in the process of completing your Information Report.

### Submission

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

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

Yours sincerely,

[Insert signature, name and title]

Enc:

- Case Summary
- Information Report Template
- Guidance on completing an Information Report

## Case Summary

*This document should be completed by the manager/administrator of the local Child Safeguarding Practice Review prior to being sent to agencies. It is designed to provide essential reference information to individual agencies when completing their Chronologies and Information Report.*

This document should be used as a reference when completing the individual agency chronologies and the Information Report.

### Background to the Case:

*Include here a background summary of the child’s death / serious injury.*

### Child’s Details:

Name:  
 D.O.B:  
 D.O.D/Serious injury:  
 Address:

### Family Composition:

*Additional family members (e.g. grandparents where they are key carers) may need to be added to the table before it is sent out.*

	NAME	D.O.B:	ADDRESS
MOTHER:			
FATHER:			
SIBLING:			
SIBLING:			

### Time Period:

The time period covered by the review has been selected to reflect the potential learning likely to be achieved. There is little value in identifying weaknesses in professional practice or procedures that have already changed. Please focus on this time period when completing your Chronologies and Information Report. 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.

*Include here time period from the terms of reference*

**Key Lines of Inquiry:**

*Include here the Key Lines of Inquiry from the Terms of Reference*

**Agency Specific Issues:**

*Include here the any agency specific issues that should be considered when completing the Information Report*



# Guidance for Agencies Completing an Information Report

## 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.

### What is an Information Report?

Information Reports are designed to analyse an agency's involvement with the child and family and any themes that have emerged. The aim is to:

- allow agencies to look openly and critically at individual and organisational practice, and the context within which people were working;
- describe actions that have already been taken;
- identify examples of good practice;
- identify any potential learning for the agency or for multi-agency arrangements.

Information Reports are not part of any disciplinary inquiry or process relating to individual practitioners. Any disciplinary action should be conducted in line with agencies established procedures and should be undertaken separately from the review.

## Purpose of this Guidance

This guidance is intended to provide specific guidance to agencies when asked to complete an Information Report for a Local Child Safeguarding Practice Review. The aim is to ensure a professional standard and consistency across agencies.

## Who Should Complete the Information Report?

Information Reports 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 Officer within the agency should **quality assure and sign off the report** prior to its submission.

Further advice and support is available from [\[insert contact details of individual able to provide advice and support\]](#).

## **How to Complete the Information Report**

### The Importance of Answering all Questions

Please make sure you carefully read and complete every question. Failure to respond to all questions is likely to result in the template being returned with a request to fill in outstanding gaps: this will delay the progress of the review and the identification of learning from this case.

**Before completing the Information Report template**, it is essential that you read both the 'Case Summary' and this guidance. You should regularly refer to both these documents when completing the Information Report Template.

In particular, please ensure that you **specifically address the identified 'Key Lines of Enquiry' and the 'Agency Specific Issues'** that are outlined on the Case Summary document.

Instructions on how to complete the Information Report are included in the report template. Additional information is, however, provided here on Question 2, Question 3.2 and Question 4.

## **Question 2: Sources of Evidence**

### Documents Used to Compile the Report

Question 2 asks you to list all the documents that were reviewed when putting together the Information Report. This may include paper records or records kept on ICT systems. You should include details of any information that was not available and why.

### Interviews

It is likely that documentary evidence will need to be supplemented by interviews with key staff to clarify ambiguity in the records. If the review of documentation suggests that policies and procedures have not been followed, relevant staff or managers should be interviewed in order to understand the reasons for this.

Staff should, where possible, be interviewed by the person responsible for completing the Information Report. The Information Report should clearly indicate where the information contained within the report has directly resulted from the interview.

It is good practice to notify individuals in writing prior to the interview. It is important that the interview process supports an open, just and learning culture and is not perceived as a disciplinary-type hearing which may intimidate and undermine the confidence of staff. The interviewer should seek to understand practitioners' and managers' perspectives and views on what happened and seek to understand why it happened at the time (rather than using hindsight). Interviews should also seek to capture views on the key areas for improvement and the challenges.

A summary of the interview should be compiled and a copy provided to the interviewee. Where there is a disagreement on the content of the summary, this should be resolved where possible or identified and noted. This interview record should not form part of the documentation submitted with the Information Report: instead, it should be used to inform the content of the report.

On completion of each Information Report, there should be a process of feedback and debriefing for the staff involved in the case.

### **Question 3.2: Contextual Information**

This section aims to capture contextual information relevant to this case that has not been included elsewhere in the Report. This may include information about the agency's involvement with the victim, perpetrator, family member or any significant others or information about organisational factors that may have influenced events.

#### Contextual Information about the Victim, Perpetrator, Family Member or any Significant Others

The individual completing the Information Report will need to decide whether it is relevant to include any contextual background / historical information held by the agency about the victim, perpetrator, family member or any significant others. This will require judgement based on the facts of the case and should be presented **as succinctly as possible**.

#### Information on the Organisational Contextual Factors

Having reviewed the information in the 'Chronology of Organisational Changes' (where completed) and the sources of evidence listed under Question 2, the individual completing the Information Report will need to decide whether additional information on organisational factors is required to understand the case. These should also be included in Section 3.2.

Wherever possible, any assertions should be evidenced by reference to policies, operational practices at that time, professional management judgement or research. The type of information that maybe useful is as follows:

- Volume of work
- Staff turnover and sickness
- Organisational change
- Unallocated cases
- The social and community context
- Management and supervision practice
- Budgetary constraints and allocation of resources
- Training and development

### **Question 4: Analysis of Involvement**

The individual completing the Information Report will need to critically analyse and evaluate the events that occurred, the decisions made, and the actions taken or not taken. This should relate to both practice and operational management. The aim is to get an understanding not only of what happened but why something either did or did not happen.

Consideration should be given to the '**Key Lines of Enquiry**' and '**Agency Specific Issues**' highlighted in the 'Case Summary' along with the following prompts:

- Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?
- When, and in what way, were the subject and any siblings' wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision-making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?
- Were there any issues in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?
- Where relevant, were appropriate Child Protection or Care plans in place, and Child Protection and/or looked after reviewing processes complied with?
- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?
- Were senior managers or other organisations and professionals involved at points in the case where they should have been?
- Was the work in this case consistent with each organisation's and the local area's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?

**NOTE: Disclosure of Information Reports**

Agencies should be aware that a request may be made by the police or court for disclosure of Information Reports 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.

Insert relevant area name and logo(s) here

Date: [insert date]

Dear Colleague,

**Reflective Learning Workshop – [Insert Date]**

We are undertaking a local Child Safeguarding Practice Review regarding [insert name of child(ren) / where appropriate the serious incident and date]. 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 of both the case and the factors or pressures that caused people to act as they did. All professionals who have had **direct involvement** with the child and/or family are, therefore, being invited to attend a Reflective Learning Workshop.

**Insert here the date, timings and venue of the Reflective Learning Workshop**

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 let me know and I will make arrangements for you to participate in another way (such as a one-to-one meeting with our Lead Reviewer).

We also plan to hold a feedback session towards the end of the review process and would appreciate if you could hold [insert date and time] in your diary.

I enclose a one-page briefing which explains more about the purpose and structure of the workshop. However, if you have any questions or concerns, please do not hesitate to contact [insert name and contact details].

Kind regards,

[Insert name and signature of relevant individual. This may be the Chair of the CSPR Group, the Lead Reviewer, or the Manager responsible for overseeing the process.]

## About the Reflective Learning Workshop

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 Learning Workshop is a crucial part of the review process. This (usually half-day) 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 workshop 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 workshop 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 Workshop

The structure of the workshop 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 workshop group will spend a short time exploring the "lived experience of the child/children". This enables participants to view what happened from the child's perspective.

- **Identifying Key Issues and Themes**

The workshop 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 workshop 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.

Insert relevant area name and logo(s) here

## Reflective Learning Workshop

**Date / Time**

**Venue**

Agenda

No	Time	Item
	9:45am	Registration
1.	10:00am	Welcome and Introductions
2.	10:05am	<p><b>Purpose of Session:</b></p> <ul style="list-style-type: none"> <li>• To understand the child's story and what life was like for them;</li> <li>• To consider what happened in the case from a multi-agency practitioner and agency perspective;</li> <li>• To identify what decisions were taken/not taken and the context;</li> <li>• To identify what could have been done differently;</li> <li>• To identify the key learning points/findings;</li> <li>• To identify improvements which are needed and to consolidate good practice, in line with the Terms of Reference.</li> </ul> <p><b>Principles for Working Together</b></p>
3.	10:20am	<p><b>Brief Outline of Terms of Reference, Methodology / Overview of the Case and Thoughts so Far - (Lead Reviewer)</b></p> <p><b>Child's Lived Experience (Timeline/story)</b></p>
4.	11:00am	<p><b>Agency Involvement with the Case:</b></p> <ul style="list-style-type: none"> <li>• Who knew what when?</li> <li>• What is new information?</li> <li>• Any surprises? <ul style="list-style-type: none"> <li>➢ What?</li> <li>➢ Why?</li> </ul> </li> <li>• Significant Influencing Factors?</li> </ul>
5.	11:30am	Break
6.	11:45am	<p><b>Key Lines of Inquiry and Questions</b></p> <p><i>Identify Key Issues for Improving Practice</i></p>
7.	12:40pm	Summary of Key Feedback Points and Any Other Reflections
8.	13:00pm	Evaluation and Close

## Reflective Learning Workshop

### Worksheets

Please read and use this workbook in line with the guidance note that you have been sent about the Reflective Learning Workshop.

**Although it is anonymised this workbook contains confidential information and should not be shared outside the review process. It should be returned when completed to [insert appropriate contact details here].**

**If possible, print off a copy to use in the meeting.** Please write your thoughts in the response book as we go through the Meeting. You will have time at the end to finish adding your thoughts.

We want to hear from you about your experiences of working with [insert name(s) of subject(s) of the review] at the time and about any systemic issues which were affecting you or your agency and which may have impacted on the work: Try and capture what worked well and what the challenges were.

- What influenced the actions or hindered them? Systems issues?
- Why did things happen or not happen?
- Was this case unique or how common is it?
- If, on reflection of your work, you have learned how you or agencies systems could or should have done something differently – let us know.
- Have we identified the right lessons from this case?
- How similar is this case to others?

Only the Review Panel will see these private responses – they are private to you and the Panel. The Panel will not see who has shared what responses. The lessons from them will be shared anonymously and summarised into the final report.

If a court of law asks for access to them, they may be disclosable.

Please add sheets if you need to, clearly numbering the questions your responses relate to.

### **Please sign and date the confidentiality statement:**

I understand that the information about this case and in the meeting in which I shall take part remains highly confidential. I will not store it, or share it, in any form, except for conversation with those in my agency or the Partnership who have a right to know.

Signed:

Date:

### **Your name and contact details:**

Name:

Agency:

Email:

Phone:

*Thank you for your assistance in this learning process. It will enable us to achieve a better understanding of the case and local systems so that we can seek to improve the way we safeguard our children.*





## **Worksheet 2**

Please use this worksheet in the meeting itself to capture your thinking, or new questions in response to what is shared with you. You will have a chance to speak as well and so you may not need to write everything down. If there are things you do not want to say in the group as a whole, you can include them here.

The Lead Reviewer will share the timeline of key contacts from all agencies in summary as we know them.

Please note any inaccuracies, any gaps or explanations if you have them. Also note your questions. The timeline will be shared in phases with an opportunity for comments and questions between each phase. The phases will be numbered – please number your responses.

### **Responses to the Summary TimeLine and learning or questions arising from it:**

#### **Phase 1 (etc)**

### **Worksheet 3**

**Responses to the Proposed Lessons / Findings,  
suggestions for any additional lessons,  
or any other questions you may have**

Please use this worksheet in the meeting itself to capture your thinking, or new questions in response to what is shared with you. You will have a chance to speak as well and so you may not need to write everything down. If there are things you do not want to say in the group as a whole, you can include them here.

The Lead Reviewer will share the possible emerging lessons that the Panel has identified.

Do they match your own experience? Are they accurate and reasonable?

Do they apply to just this case or wider across more cases?

Have you identified any additional lessons?

Please put your response to each lesson below. They will be numbered on the screen.

**Proposed lesson 1 (etc)**

## **Worksheet 4**

### **Feedback on this learning process as part of the review**

It would help us to plan similar events to get your feedback on this process.

### **What worked? What could have been improved?**

1. Did you have enough information in advance to explain the purpose and process of the meeting? (Too much?)
2. Could anything more have been done to help you prepare?
3. Were you supported? What helped that or what prevented that?
4. Were you able to contribute to the meeting? What helped and what hindered?
5. Do you have any additional thoughts that could have improved this process?
6. Would you like to speak privately with the Lead Reviewer/s?

# Guidance on drafting the Report

## 1. Background

National research and analysis of both reports for Serious Case Reviews (the predecessor to Local Child Safeguarding Practice Reviews) and reports produced for Local Child Safeguarding Practice Reviews (LCSPRs) repeatedly highlight the variation in the format and quality of the final reports.

The structure of final reports for LCSPRs will need to vary according to the individual case being reviewed. However, this brief guidance document highlights the key elements that Safeguarding Partners in the wider West Midlands will expect to see in the reports they commission.

## 2. Minimum Requirements

Reports should be focused and succinct, with relevant, clear content from which the analysis, learning and conclusions logically and explicitly flow. The report should give a sense of the distinct context for the child and what their daily life was like. It should speak to front-line practitioners as well as leaders and senior managers.

Reports should be written in a way that avoids harming the welfare of any children or vulnerable adults in the case. The author of the report (normally the Lead Reviewer) should ensure information is appropriately anonymised (see section 3.1 below) and is written with publication in mind.

Where the views of surviving children or family members have not been included in the review, a short statement should be included detailing the reasons why.

Every LCSPR should have clearly framed questions that the review seeks to answer. Reports should address these questions and meet any other requirements specified in the agreed Terms of Reference. As a minimum, the report should also succinctly include:

- a brief overview of what happened and the key circumstances, background and context of the case. This should be concise but sufficient to understand the context for the learning and recommendations;
- an analysis of **why** relevant decisions by professionals were taken, including the conditions in which practice took place;
- 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. (This should include local learning as well as any implications for national policy and practice).<sup>21</sup>

## 3. Good Practice

When drafting reports, it is worth considering the following:

### 3.1 Language and terminology

- Reports should be written clearly in plain English.

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<sup>21</sup> Some areas in the wider West Midlands may choose to convene a dedicated group to consider the learning and how this can be developed into meaningful recommendations. Lead Reviewers should check the approach being taken and whether or not recommendations are required.

- A glossary can be helpful as a check for unfamiliar terms and acronyms (although not when a wide range of acronyms are used). Authors of reports should be aware that acronyms for local organisations make little sense to those reading the report beyond the local area.
- Reports should be written in a way that avoids harming the welfare of any children or vulnerable 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 names of the child who is subject of the review and their family members should be anonymised in a way that ensures the report remains easy to read. For example, reports where each family member is given a reference letter or number can be hard to follow. It is frequently easier to follow the report's narrative when the child is given a pseudonym and family members are referred to by their relationship to the child e.g. Mother, Father, Stepmother, Maternal Grandfather, Sister, Brother etc.

### 3.2 Structure of the Report

- The inclusion of a 'Contents' page can make reports more accessible to the reader.
- Similarly, the National Child Safeguarding Review Panel recommend the inclusion of an executive summary of no more than 2 A4 pages.
- Reports should be **as short as possible** to meet the requirements outlined above. Only **relevant** information should be included.
- The provision of a concise summary of relevant family history and past agency contact can help provide a context for understanding how the past affected events and aid the understanding of why and how the child died or was seriously harmed.
- Having a dedicated section about the child frequently provides the report with a strong focus and ensures the child's voice is considered.
- Repetition of events often gets in the way of analysis. For example, when detailed accounts of agency involvement are included and then revisited as part of the analysis. The reader should not, however, be required to constantly cross-reference to other parts of the report.

### 3.3 Analysis

The purpose of a LCSPR is to **analyse** the case not simply to describe what happened. This includes asking questions such as:

- Why were key decisions made?
- Why were critical observations missed or simply ignored?
- Why did circumstances exist which caused sometimes terrible detriment to one or more children?

The focus should be on what caused something to happen and how it can be prevented from happening again. Lead Reviewers and Review Teams should probe behind the first information or first answers they are given, whether from service users or other practitioners. Their analysis of events should ask these 'second questions' in order to get the heart of what was missing, why and how change can be achieved.

Systems factors should be considered. This includes policies, procedures and organisational changes as well as leadership, culture, and human motivations (such as the impact of fear, exhaustion, overwork etc.). The review should consider relevant failings and good practice and policy at all levels.

Many strong reports explicitly flag where the analysis highlights a learning point (e.g. by stating 'Learning Point 1'). This can help make the link between the analysis and the learning points / recommendations.

### 3.4 Learning Points / recommendations

This learning should be identified separately in the final report, before any recommendations. The report should also explain the link between the learning identified and the specific recommendations.

It can be useful to use headings that sum up the emerging themes and learning points. (For example, 'Inter-agency communication' or 'The use of written agreements.')

Some areas in the wider West Midlands may choose to convene a dedicated group to consider how learning points are developed into meaningful recommendations. Lead Reviewers should check the approach being taken.

Any recommendations should be few in number and focused on improving practice, rather than simply increasing bureaucracy with more procedures and rules, monitoring and control. Reviews should avoid making recommendations that are vague and general, repeating what should be standard practice, or that seek assurance around issues that should have been covered in the review itself.

Recommendations should be clear and addressed to named people or organisations locally and nationally. They should clearly articulate how change might come about and how the effectiveness of any change in practice will be assessed and measured.

#### **4. Checklist – Quality Markers**

The Social Care Institute of Excellence / NSPCC 'Quality Markers' include seven questions that reviewers may wish to consider when drafting their report:

- Does the structure of the report make it straightforward to identify relevant analysis and findings, so as to assist other local areas to identify learning that is pertinent to them and to assist the collation of learning at a national level?
- Does the amount of information provided in the report satisfy the need for privacy of family members and individual staff while providing sufficient information to make accessible the analysis, in order that it can support necessary improvement work?
- Does the report contain findings and/or recommendations that reflect the areas deemed as priority for improvement?
- Do these findings and/or recommendations address explanations of practice or remain only descriptive of issues identified in how professionals handled the case?
- Is there transparency in how conclusions have been reached?
- Does the report adequately manage accessibility and explaining complex professional and organisational issues?
- Is the tone and choice of words appropriate to the review?





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