# Document 5: Terms of Reference

## Local Child Safeguarding Practice Review

## Terms of Reference

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| DATE: |  | CHILD REFERENCE |  |

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| 1 | INTRODUCTION |
| 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.  **The Purpose**   * The purpose of a child safeguarding practice review is to explore how practice can be improved through changes to the system itself. * Reviews should seek to understand both why mistakes were made and to comprehend whether mistakes made on one case frequently happen elsewhere.[[1]](#footnote-1) |
| 2 | BACKGROUND TO THE REVIEW |
| **Summary of Serious Incident:**  **Information about the Family:** |
| 3 | REVIEW TEAM |
| **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).* |
| 4 | SCOPE OF THE REVIEW |
| **Time Period to be Considered by the Review and Rationale:**  **Key Issues to be Addressed by the Review:**  (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.)  **Research questions**  In reviewing the information provided for the rapid review NSSCP is undertaking this child safeguarding practice review in order to understand what this case can tell us about:  **Issues which have been identified as requiring particular analysis are:** |
| 5 | PLANS TO INVOLVE CHILDREN AND FAMILY MEMBERS |
| NOTE: Plans to engage children and family members will need to take into account the legal considerations outlined in Section 4 below.  This section should describe the agreed plans to involve children and family members and who will be responsible for making contact / following up. |
| 6 | METHODOLOGY |
| NOTE: 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.  The review will be conducted using a systems approach, not attached to a specific methodology. The review will consist of the following phases:   * Data gathering and the development of a reconstruction (without the benefit of hindsight) of what was knowable at the time and the actions of the practitioners involved in the case through: conversations with key practitioners, written records and data and policies and procedures. * Appraisal of practice and explanation – the use of a practitioner workshop and meetings with the review panel to agree and appraise key practice episodes * Discussions with the young person (if applicable) and with their family members * Agree findings and recommendations that are relevant to the wider system in North Somerset   **Learning Template / Information Report:**  Each agency involved will prepare and submit a chronology and analysis of their organisation’s involvement.  **Reflective Learning Workshop / Feedback Session:** |
| 7 | LEGAL CONSIDERATIONS |
| **Parallel Investigations:**  **Legal Advice:** |
| 8 | OTHER CONSIDERATIONS |
| *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.* |
| 9 | TIMELINE AND KEY DATES |
| *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.*  Appointment of Independent Reviewer date  Meeting between Author, CSPR Subgroup Chair date  Authors Briefing date  Author Templates to be returned date  Review Panel Meeting (1) date  Practitioner Workshop date  Meetings with young person (if relevant) and family members date  Review Panel Meeting (2) date  Final Report to NSSCP date  Final Report to Ofsted date |

## Guidance on drafting the Report

### 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.

### 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).[[2]](#footnote-2)

### Good Practice

When drafting reports, it is worth considering the following:

3.1 Language and terminology

* Reports should be written clearly in plain English.
* 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.

### 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?

1. This definition is taken from the Practice Guidance issued by the National Child Safeguarding Review Panel on 5 April 2019. [↑](#footnote-ref-1)
2. 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. [↑](#footnote-ref-2)