Child Safeguarding Practice Reviews (CSPRs) in North Somerset

Practice Guidance Supporting Documents

Use this booklet to browse all supporting documents before downloading the appropriate editable file.

NSSCP
NORTH SOMERSET
Safeguarding Children Partnership

April 2024

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 & Rapid Review Template
Document 4: Template Letter – Submitting the Rapid Review Template to the National Panel

Agreeing the Scope and Terms of Reference
Document 5: Terms of Reference Template to include document 18

Engaging Children and Family Members
Document 6: Template Letter – Informing Family Members of a Review
Document 7: Sample Leaflet – Local Child Safeguarding Practice Reviews

Methodology
Document 8: Sample Chronology Templates
Document 9: Template Letter – Request to complete a Chronology
Document 10: Guidance on Completing the Chronologies
Document 11: Learning Template
Document 12: Guidance on Completing an Information Report
Document 13: Template Letter – Invitation to Reflective Learning Workshop

Embedding Learning
Document 14: Sample Action Plan Template

Document 1 - 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 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 2018 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.

Document 1a: Referral Form
Request for a Child Safeguarding Practice Review

Before submitting the referral, please check the criteria in appendix 3 of this form. Once completed, please send this form to:

zoe.gartland@n-somerset.gov.uk

1. Referrer

Name:		Email:	
Role:		Tel:	
Agency:		Date submitted:	

2. Details of child or young person

Name of child:		Date of birth:	
Home address:		Date of death or critical incident:	
Carer:		Location of incident:	

Ethnic origin:		
(A) White	**(B) Mixed**	**(C) Asian or Asian British**
☐ British ☐ Irish ☐ Any other White Background	☐ Asian and White ☐ Black African and White ☐ Black Caribbean and White ☐ Any other mixed background	☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Any other Asian background
(D) Black or Black British	**(E) Other Ethnic Groups**	**(F) Not Declared**
☐ Caribbean ☐ African ☐ Any other Black background	Please specify	☐ Not Declared

Faith:		**Disability:**	

Child protection plan:	☐ Yes ☐ No ☐ Has been ☐ Not known

3. Composition of family and significant others

Name	Relationship to child	DoB	Address	Ethnic origin
Add rows as needed				

4. Rapid Review criteria

Please demonstrate how you believe the criteria for a Rapid Review to be met. The criteria can be found in **Appendix 1.**

Criterion	Yes	no
Is the child deceased?	☐	☐
Is the child seriously harmed (please describe below)?	☐	☐
Is abuse or neglect known or suspected to be a cause of the death or harm to the child?	☐ Known ☐ Suspected	☐
Is there a cause for concern as to the way in which agencies or other relevant persons have worked together to safeguard the child?	☐	☐

5. Summary of events

Please provide a summary of the events leading to the death or harm caused to the child, making clear why you believe that these circumstances meet the criteria for SCR.

6. Other information

If you are aware of any other agencies involved in the care of this child, please list below:

Name	Agency	Contact details	Are they still involved?
Please add rows as needed			

If you aware of any other processes that this case is currently subject to, ie. Coroner's inquest, Child Death Overview Panel, criminal proceedings, etc. please list below:

Process	Current status

Document 2 – Initial Scoping and Information Sharing Template
Proforma for Rapid Review

1. CHILD AND FAMILY DETAILS					
Name of child(ren):				**Date of Birth:**	
Child's ethnicity				**Religion**	
Sex at birth (and gender identity if different)				**Disability**	
Associated Addresses:					
Family details:	**Name**	**D.O.B**	**Address**		
Related Adults:					
Related Children:					
Report prepared by:	**Nam**		**Role**		

2. YOUR AGENCY INVOLVEMENT	
Professional roles with child/family	
Name of involved professional:	
Date involvement started:	
Reason for involvement (if applicable)	
Summary of involvement. **What were the key events for your agency, and what was the impact for this child?**	
Please comment on the voice of the child(ren) in describing their lived experience	

3. INTERAGENCY WORKING

Which other agencies were you in direct contact with in working with this family, and was there information missing from these in your records that would have helped form a more robust assessment of need and risk?

Agency	State if you were in contact with this agency about this family	State if your notes are missing information from this agency that would have helped form a more robust assessment of need and risk
GP		
Midwifery		

Health Visiting Service		
School Nursing Service		
Children & Young People Mental Health Service (CAMHS)		
Perinatal Mental Health Community Service		
Adult Mental Health Services		
SWAST (ambulance)		
A&E/Minor Injuries Unit		
Domestic Abuse Services		
Substance Misuse Services		
Adult Social Care		
Children's Social Care		
Early Help		
Youth Offending Service		
LADO		
Police		
Fire & Rescue Service		
Probation		
CAFCASS		
Education/Childcare provider		
Housing		
Hospital Trust (please name)		
Other Local Authority (please name)		
Other agency e.g. voluntary (please name)		
Please expand on any missing information here:		

4.	**ANALYSIS OF INVOLVEMENT**
What has worked well?	
What are the learning points within your agency?	
What are the learning points across agencies?	

Please suggest single and multiagency actions. Actions should be SMART. The Rapid Review Panel will create a single action plan derived from all of the suggested actions. Not all suggested actions will be included.				
	Action	**Lead**	**Deadline**	**Progress**
1				
2				
3				
4				

Document 2a: Template Letter -Request for Initial Information

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 NSSCP

Enc: Initial Scoping and Information Sharing Form

Document 3: Agenda for a Rapid Review Meeting including Rapid Review Template

REPORT OF RAPID REVIEW DECISIONS AND RECOMMENDATIONS FOR SUBMISSION TO NATIONAL CHILD SAFEGUARDING PRACTICE REVIEW PANEL

Purpose of the Rapid Review

In line with Working Together 2018, 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.

List of participants in Rapid Review

Agency	**Membership**

Background Information

***Name of Child**:*

***Date of Rapid Review**:*

Assigned Gender

Gender Identity (Sex assigned at birth and gender identity if different)

Ethnicity

Religion

Any disability

Review Period Date and Summary:

Documentation available to this Rapid Review:

Case Summary received from:

The following services were considered, and information gathered to ascertain if they should be notified and asked to check whether they had any information on the family during the review period and provided a nil return:

Rapid Review Discussion

VOICE OF THE CHILD/REN:

VOICE OF THE PARENTS:

GOOD PRACTICE POINTS

-

LEARNING THEMES AND ACTIONS

Recommendation

The panel considered Safeguarding Children Practice Review criteria:

Significant injury or death

Concern about agencies working together

Safeguarding concerns

<u>CSPR Decision Recommendation</u>

The opinion of the review is that this case does/does not meet the criteria for CSPR

Rationale:

References

Document 4: Template Letter – Submitting the Rapid Review to the National Panel

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 NAME the partnership's Independent Scrutineer /Chair].

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

Document 5: Terms of Reference

Local Child Safeguarding Practice Review
Terms of Reference

DATE:		CHILD REFERENCE	

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]
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.)

[1] This definition is taken from the Practice Guidance issued by the National Child Safeguarding Review Panel on 5 April 2019.

	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

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).[2]

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.
- 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

[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.

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?

Document 6: Template Letter – Informing Family Members of a Review

Add Address 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

Get In Touch!

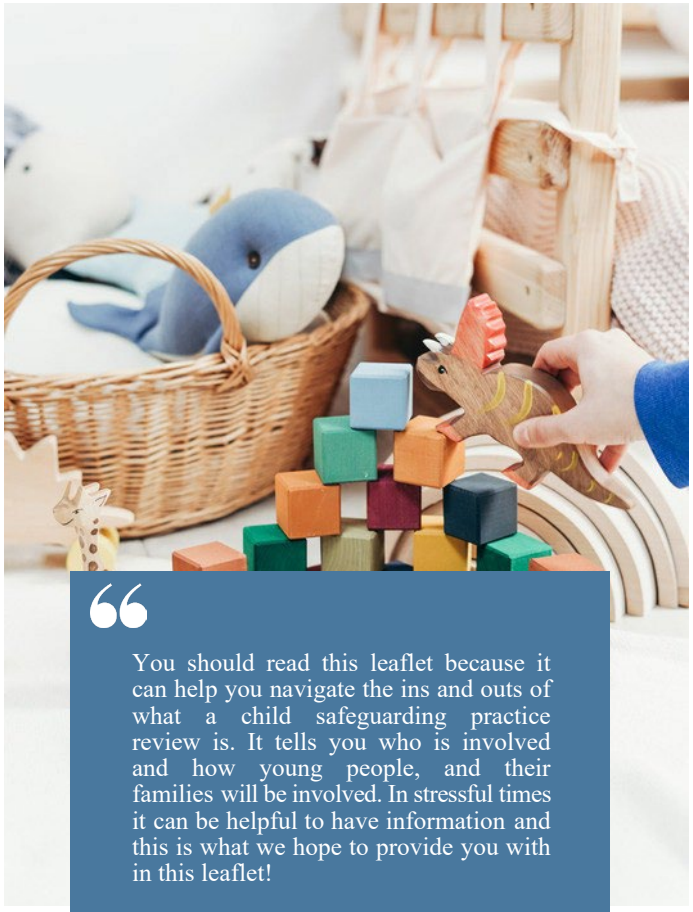
Your Lead Reviewer Is:

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

Phone number

Email

Why Should I Read This?



You should read this leaflet because it can help you navigate the ins and outs of what a child safeguarding practice review is. It tells you who is involved and how young people, and their families will be involved. In stressful times it can be helpful to have information and this is what we hope to provide you with in this leaflet!

Bethany Swann, Young Director.

NSSCP NORTH SOMERSET Safeguarding Children Partnership

NSSCP NORTH SOMERSET Safeguarding Children Partnership

Child Safeguarding Practice Reviews

Information for parents, carers and young people.

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;
- 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 you or 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 Young People, 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 young people and 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.

Chronology – confidential!

This is an illustration - document is attached as an Excel spreadsheet.

Child(ren) name(s):	**[Subject Name]**
Agency:	**[Agency Name]**
Author:	**[Author name]**

Date	Time	Which Child?	Agency	Source of Information	Description of agency activity/event	Comments
Please use the date format dd/mm/yyy. Please give date of contact / information received in agency, not the date of the event so it is clear who knew what and when	Use if there are multiple events in the same day using format hh:mm	state which child the information relates to (or "all" if relevant)	Name of service within your organisation	Please state the documents in which this information was recorded. This is to enable identification of any documents that need to be read	Please provide a record of the contact your agency had with the case subject. The aim is to understand what each individual agency knew at the time. Remember to provide actual names of staff that are involved in the entry (from whatever agency) as they appear in your records: this will allow identification of the case group. No names will appear in subsequent working papers or reports.	The comments column is for you to provide any additional explanation of your agency's systems and processes which may be required to understand the entry. Please additionally provide a glossary of terms and abbreviations used and a list of staff identified in any agency and their post / designation.

Document 9: Template letter – Request to Complete a Chronology

Add 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

Document 10: Guidance for Agencies Completing the Chronologies

Background Information

The Purpose of Child Safeguarding Practice Reviews

Working Together to Safeguard Children 2018 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 2018 defines serious child safeguarding cases as those in which:

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

Serious harm includes (but is not limited to) impairment of physical health **and** serious / long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development (although this is not an exhaustive list). *Working Together 2018* advises that consideration be given to whether impairment is likely to be long-term, even if this is not immediately obvious. Even if a child recovers, serious harm may still have occurred.

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

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.

Document 11: Child Safeguarding Practice Review Learning Template

GUIDANCE FOR COMPLETION

1. Section 1	*This should only be completed once at the beginning of the document*
2. Agency	*If agencies have provided multiple services to the child / family all the provision should be merged into one learning document.*
3. Author Including Designation and Contact Details	*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.*
4. Senior Agency Lead Including Designation and Contact Details	*The single agency learning summary should be signed off by the organisation at an executive level.*
5. Section 2	*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*
6. Section 3	*This should be completed for each theme or key line of enquiry.*
7. Section 4	*This should be competed for each significant event that falls outside the of the key lines of enquiry.*
8. Significant Practice Event / Issue / Key Line of Enquiry:	*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.* ***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***
9. Section 5	*This should include a brief synopsis of agency actions relating to the subject child and their family post review period.*
10. Analysis	*Your analysis of safeguarding practice is crucial…. This could include;* • *at the time' reflection and expectations of practice.* • *provide context where relevant e.g. resource/staffing issues/handovers, learning opportunities/deficits, relevant policies, procedures, protocols and operating frameworks, national context* • *management oversight and strategic monitoring arrangements*

	• *areas for development and improvements made to practice following the event/issue/KLOE.* • *Consideration of areas still requiring action/improvement.* • *multiagency partnership working arrangements.* • *effectiveness of cross boundary arrangements.* • *evidence and research base.*
11. Recommendation	*Recommendations are specific and overarching. Normally action points fall out of the recommendations*
12. Highlight Good Practice	*Remember to pull out good practice and what worked well*

SECTION 1:

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

SECTION 2:

SYNOPSIS OF AGENCY INVOLVEMENT PRIOR TO THE REVIEW PERIOD AND ADDITIONAL LEARNING: **(Review period: (ADD Dates)**	

SECTION 3:

SIGNIFICANT PRACTICE EVENT / ISSUE / KEY LINE OF ENQUIRY 1:	
ANALYSIS:	
RECOMMENDATION:	
HIGHLIGHT GOOD PRACTICE:	

SIGNIFICANT PRACTICE EVENT / ISSUE / KEY LINE OF ENQUIRY 2:	
ANALYSIS:	
RECOMMENDATION:	
HIGHLIGHT GOOD PRACTICE:	

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

SIGNIFICANT PRACTICE EVENT / ISSUE / KEY LINE OF ENQUIRY 4:	
ANALYSIS:	

RECOMMENDATION:	
HIGHLIGHT GOOD PRACTICE:	

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

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

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

SECTION 4

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

SECTION 5

SYNOPSIS OF AGENCY INVOLVEMENT POST THE REVIEW PERIOD AND ADDITIONAL LEARNING	

Document 12: Guidance for Agencies Completing an Information Report

Background Information

The Purpose of Child Safeguarding Practice Reviews

Working Together to Safeguard Children 2018 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

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- 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 2018* advises that consideration be given to whether impairment is likely to be long-term, even if this is not immediately obvious. Even if a child recovers, serious harm may still have occurred.

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

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.

Document 13: Template Letter – Invitation to a Reflective Learning Workshop

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.]

Document 14: Local Child Safeguarding Practice Reviews - Action Plan Template

Learning Point/ Recommendation	Agreed Actions	Responsible Person	Timescale	Actions Taken	Progress Update (and RAG rating)	Evidence of impact / outcome

North Somerset Safeguarding Children Partnership
North Somerset Council
Town Hall
Walliscote Grove Road
Weston-super-Mare
BS23 1UJ

zoe.gartland@n-somerset.gov.uk

Date of Publication: April 2024
Date of Review: April 2025