Child Safeguarding Practice Reviews (CSPRs) in North Somerset

Practice Guidance

NSSCP
NORTH SOMERSET
Safeguarding Children Partnership

April 2024

Contents

Who is the Toolkit and Guidance for?

This toolkit and guidance were 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

This guidance provides North Somerset Safeguarding Children Partnership 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 guidance and supporting documents have been endorsed by safeguarding partners across the three agencies: local authority, ICB and police. This guidance will continue to be reviewed and updated to reflect changes in national guidance and emerging good practice.

North Somerset Council

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Avon and Somerset Police
SERVE.PROTECT.RESPECT.

1. Introduction and Context

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 (a person under the age of 18). 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).
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).*

1.1.3 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.

1.1.4 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.

1.1.5 The guidance and template documents / letters should not be seen as a prescriptive process or approach. Instead, members of the partnership 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 and Criteria for Child Safeguarding Practice Reviews

1.2.1 '[1]The purpose of undertaking a CSPR is to provide learning to improve safeguarding practice at a local level and to avoid similar incidents occurring in the future. There are situations where the actions of professionals, or failure to act by partners and relevant agencies, contribute to or exacerbate the harm suffered by children. Above all there is always more that we can learn and do to improve our systems and working practices. Reviews that are undertaken should be done with the aim of acquiring additional learning to improve practice.'

1.2.2 Holding organisations and their leaders to account for the quality of services, and individuals to account for not meeting professional standards, are essential pre-requisites for public confidence in the national safeguarding system. Regulatory bodies for the professions hold this key role. Reviews are not designed for this purpose and should not be used in this way. Nevertheless, where reviews identify

[1] This definition is taken from the Practice Guidance issued by the National Child Safeguarding Review Panel, September 2022 and the Annual Report, January 2024.

any actual or potential errors or violations, they should ensure that proper lines of accountability are followed to ensure that those responsible are held to account.

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.[2]

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 A child who has caused harm 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[3] 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 for 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.[4]

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

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[2] This is not an exhaustive list.

[3] By the Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018.

[4] 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.

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 2023*, 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 North Somerset will conduct Local Child Safeguarding Practice Reviews in line with good practice and the principles of the systems methodology recommended by the Munro Report.[5] 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'[6].

1.5.3 Decisions on whether to undertake a review will be made transparently and the rationale shared with all relevant partners (including families if a CSPR is commissioned).

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;

[5] 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).

[6] 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.

- 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 in the appendices.

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 North Somerset has a standing Child Safeguarding Practice Review Group made up of representatives from the Safeguarding Partners in their area along with any relevant safeguarding experts from partner agencies. This group will undertake a Rapid Review of each serious incident referred to them and will take responsibility for commissioning and overseeing any Local Child Safeguarding Practice Reviews. This will include monitoring case progression, quality assurance and publication of final reports, and ensuring effective oversight of the implementation of learning.

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.[7]

[7] This is separate from the formal requirement on local authorities in England to notify the national Child Safeguarding Practice Review Panel and the relevant local safeguarding partners if a child dies or is seriously harmed in their area (or outside of England while they are normally resident in the local authority area) and their duty to notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected.

2. Information Sharing

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 There is a duty amongst all agencies to respond to requests for information to support both national and local Child Safeguarding Practice Reviews.

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 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 NSSCP Executives for formal action.

3. Timescale for Completion of the Review

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. The NSSCP CSPR group will convene within 5 days of a referral to decide whether to notify.

3.1.3 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.

4. Deciding whether to undertake a Child Safeguarding Practice Review

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 This duty to notify serious incidents 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.[8] The CSPR group will convene within 5 working days of a referral to decide whether to notify.

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 to notify. Guidance on whether to notify an incident is included in the appendices.

4.1.4 A decision should be undertaken jointly in most cases, however, 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 in appendices.

[8] 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.

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 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 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.

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 in the appendices. These timescales are indicative only and may be adapted as necessary, ensuring 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 is available as part of this toolkit along with a sample letter to accompany the template.

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 The CSPR group will send out the scoping document to all relevant agencies **within 2 working days** of agreeing to make a notification, along with an accompanying letter that briefly outlines the referral and explains the purpose of this initial scoping. (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 ensure all records/files in relation to the case are securely stored.

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 NSSCP has a standing group to undertake Rapid Reviews and oversee LCSPRs.

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;
- 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 will be undertaken by the CSPR panel and will include representatives from each of the statutory safeguarding partners (BNSSG ICB, Avon and Somerset Police and North Somerset 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 Practice Learning 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 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 an appendix.

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?
- Can any relevant national reviews be referenced and used to support local learning?
- 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?

4.6.5 A thorough Rapid Review may mean that there is no need for a separate Local Child Safeguarding Practice Review and NSSCP 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.

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 and should be shared and agreed by those attending the Rapid Review meeting.

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.

North Somerset may wish to ask and Independent Scutineer 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 in appendices.

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. The end of a Rapid Review should result in a learning brief, action plan (created with the involvement of the Quality Assurance and Learning & Development Subgroups), dissemination mechanism to agencies and monitoring mechanism within NSSCP.

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 – see flowchart below

Child Safeguarding Practice Review (CSPR) Process Flowchart

Child dies or is seriously harmed in North Somerset or, if outside of England, is usually resident there *and* concerns identified about the way organisations have worked together to safeguard a child from abuse or neglect.

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Organisation or individual notifies North Somerset Head of Service for Safeguarding and Quality Assurance and completes a Child Safeguarding Practice Review (CSPR) referral form returned securely to NSSCP business manager.

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North Somerset Safeguarding and QA team decides if a serious incident notification to national CSPR Panel should be made by convening NSSCP CSPR subgroup. If agreed, they recommend a Rapid Review and with which organisations within 5 working days of becoming aware of the incident. NSSCP business manager and safeguarding partners informed of decision.

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If notified, within one working day the national CSPR Panel request a Rapid Review is undertaken to establish whether a CSPR should be undertaken within 15 days of serious incident.

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NSSCP Executive notified of national panel decision.
NSSCP business manager circulates rapid review templates. Agencies complete and return within 10 days.
CSPR subgroup meet within 15 working days of notification to conduct Rapid Review making recommendation to NSSCP Executive if case meets criteria for CSPR. Emerging lessons shared with partners.

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Written submission to the national CSPR Panel within 15 working days to inform them of the recommendation.

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National CSPR Panel meet and consider their response to the submission. They write to inform the Partnership of their decision if a local CSPR is needed (or that they will conduct a national review) within 15 working days of receiving the Rapid Review. CSPR can only commence after this process is complete.

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NSSCP Subgroup Chair and business manager write to inform the referrer and key agencies that a CSPR will commence.

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Actions led by the Subgroup:

- ✓ Decide on format of additional learning event
- ✓ Appoint a lead reviewer, if required
- ✓ Agree who should form the Review Group to ensure that key organisations involved in the case are represented by a manager of sufficient seniority.
- ✓ Identify staff to be included in the Practitioner Group i.e. the staff and managers who were directly involved with the child and their family
- ✓ Inform family members about the review
- ✓ Draft Terms of Reference for the CSPR
- ✓ Agree template for chronologies

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Completion of review should be within 6 months and a copy must be submitted to the national CSPR Panel prior to publication.

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CSPR commences.

5. Agreeing the Scope and Terms of Reference for a CSPR

5.1 The Child Safeguarding Practice Review Group will formally agree the scope and terms of reference for the review. To do this, they 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.

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. Participation of families in Rapid Reviews are not usually possible.

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[9]. 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, it may not be possible to speak to certain witnesses if this could prejudice a criminal investigation. 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.

[9] 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

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 CSPR subgroup, facilitate the learning workshops and author the final report, including a summary for the family. 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
- SCR.SIN@ofsted.gov.uk
- Mailbox.CPOD@education.gov.uk

6.2 The CSPR Subgroup

6.2.1 For complex reviews, the CSPR subgroup (a small, multi-agency team) will assist the review process along with relevant service leads as required. 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 CSPR subgroup will support the Lead Reviewer to scrutinise the information provided by agencies. The group 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

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[10] 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 confirm a full and accurate **genogram** to assist the clarification of family relationships and dynamics. 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 (age and comprehension level depending). 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 and leaflet in the appendices.

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 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.

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

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

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 review'* 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 North Somerset. These are consistent with both the guidance in *Working Together 2023* and the principles of the systems methodology recommended by the Munro Report.[11]

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

[11] 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 will involve a standardised agency response form and may include chronologies or other evidence.

8.5 Chronologies

8.5.1 Chronologies will sometimes be requested if it will help the independent reviewer 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 will 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 and Information Report Template are provided in the supporting documents, along with a sample Accompanying Letter and Guidance Notes on Completing the Information Report.

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. This takes place whilst maintaining a narrow TOR to prevent independent authors heading off on a tangent to the main learning themes.

8.7 Independent Author Presents to CSPR group

8.7.1 The work of the CSPR team, chaired by the Lead Reviewer, builds on the initial scoping information and Rapid Review. They need 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 CSPR group 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 Whilst, chronologies are no longer routinely used, key themes are identified at Rapid Review (although they may be edited or expanded during the CSPR).

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 CSPR group to identify important multi-agency learning.

8.10 Preparing for a Learning Workshop

8.10.1 The CSPR group 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 other information.

8.10.2 To maximise learning all agencies are expected to ensure that appropriate staff attend the workshop. Typically, front line practitioners plus their safeguarding leads attend (safeguarding leads provide wider context to the information shared that front line practitioners do not know).

8.10.3 Invitations to a reflective learning workshop (in appendices) 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.

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 in appendices.)

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.

8.11.3 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[12];
- 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 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 / CSPR group 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 will be via email.

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

9. The Report

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 in appendices.

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[13]:

- 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.

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

[13] 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'*.

develop the formal recommendations. North Somerset Safeguarding Children Partnership 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 NSSCP Executives before being included in the report.

10. Publication

10.1 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.

10.1.2 Safeguarding partners are required to publish the reports of Local Child Safeguarding Practice Reviews, unless they (in collaboration with the Child Practice Review Group) consider it inappropriate to do so.[14]

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 The central point of contact for all media enquiries will be the Assistant Director for North Somerset Children's Services. This individual will 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
- SCR.SIN@ofsted.gov.uk
- 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

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

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

11. Embedding Learning

11.1 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[15]. 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 North Somerset Safeguarding Children Partnership, 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 is in place and is an identical process to the post-rapid review sharing and action plan creation. (See Section 4.7.)

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 is included in the supporting documents.

11.5 Taking into Account Learning from National Reviews

11.5.1 The NSSCP will also review key learning from reviews in other areas and consider how it can be applied at a local level.

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[15] 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 corrective action and disseminate learning.'*

Appendix 1

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.

Appendix 2

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

In your role as a member of, or attendee at, one of the NSSCP'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 NSSCP's 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	**AGENCY AND FULL CONTACT DETAILS** (Postal address, telephone number and email.)	SIGNATURE
1.		

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

Appendix 3

Criteria for referring cases to the NSSCP

Statutory guidance from Working Together to Safeguard Children 2023 on Child Safeguarding Practice Reviews

The criteria described for serious child safeguarding cases are those in which:

• abuse or neglect of a child is known or suspected

• the child has died or been seriously harmed

Serious harm[16] is described as including '(but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.' Impairment of physical health should also be considered.

Meeting these criteria will not automatically mean a Safeguarding Practice Review will occur, as the subgroup will determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice. Issues might appear to be the same in some child safeguarding cases but reasons for actions and behaviours may be different and so there may be different learning to be gained from similar cases. Decisions on whether to undertake reviews should be made transparently and the rationale communicated appropriately, including to families. The subgroup may decide that a local or single agency review is more appropriate.

Notification to the national CSPR Panel must occur in all the following cases:

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

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

The local authority must also notify the Secretary of State for Education and Ofsted of any death of a looked after child or care leaver up to and including the age of 24.

[16] Serious harm is defined as under Working Together 2023 but further guidance from the National Review Panel should be referred to.

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