Safeguarding Children Partnership Board

Guidance on Child Safeguarding Practice Reviews

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Introduction

The Children and Social Work Act 2017 introduced a new legal framework in respect of local safeguarding arrangements for children. Responsibility for how a system learns lessons from serious child safeguarding incidents now rests at a national level with the Child Safeguarding Practice Review Panel and at a local level with the three Safeguarding Partners (clinical commissioning groups, police and local authorities).

Local areas will no longer conduct Serious Case Reviews. Instead, they need to consider whether to conduct a *Local Child Safeguarding Practice Review* (CSPR) in cases where abuse or neglect of a child is known or suspected and the child has died or been seriously harmed.

This guidance provides professionals with a step by step guide to follow when undertaking or participating in a Local Child Safeguarding Practice Review. It describes the approach, order of events and related timescales whilst also highlighting the key statutory elements outlined in *Working Together to Safeguard Children 2018*. It also outlines responsibilities for key people at every stage of the process and includes template documents and letters.

Purpose and Criteria for Child Safeguarding Practice Reviews

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. 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. Employers should consider whether any disciplinary action should be taken against practitioners whose conduct and/or practice falls below acceptable standards and should refer to their regulatory body as appropriate.

Definition of a Serious Child Safeguarding Case

Working Together 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) serious **and/or** long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health[1].

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.

[1] This is not an exhaustive list.

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

Criteria for a local safeguarding practice review

Safeguarding Partners are required to consider the criteria and guidance when determining whether to carry out a Local Child Safeguarding Practice Review. They **must take into account** whether the case[2]:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified;
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children;
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children;
- is one which the Child Safeguarding Practice Review Panel have considered and concluded that a local review may be more appropriate.

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

- where the Safeguarding Partners have cause for concern about the actions of a single agency;
- where there has been no agency involvement and this gives the Safeguarding Partners cause for concern;
- where more than one local authority, police area or clinical commissioning group 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.[3]

Meeting the criteria does not mean a local Child Safeguarding Practice Review must automatically be undertaken. Instead, the process outlined in this document will be followed to determine whether a review is appropriate (i.e. whether there is potential to identify improvements.)

Child safeguarding reviews may also be undertaken for cases which do not meet the definition of a '**serious child safeguarding case**' if they raise issues of importance that could generate learning. *Working Together 2018*, for example, suggests they might take place where there has been good practice, poor practice or where there have been 'near miss' events.

Alternative learning reviews will always be considered if the decision is not to proceed with a formal Child Safeguarding Practice Review. *Appendix 1* provides a summary of the different review and audit methodologies that may be used to identify and disseminate learning.

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

[3] 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.

Approach and Principles

All Child Safeguarding Practice Reviews and other learning reviews will be undertaken in line with good practice and the principles of the systems methodology recommended by the Munro Report.[4] This includes the advice outlined in *Working Together 2018* and its predecessor documents as well as the good practice principles described in the SCIE / NSPCC 'Quality Markers'[5].

All reviews will be proportionate to the circumstances of the case and focus on the potential learning. Specifically all reviews will be conducted in a way which:

- reflects the child's perspective and family context;
- considers and analyses frontline practice as well as organisational structures and learning;
- establishes the reasons why events occurred as they did;
- reaches recommendations that will improve outcomes for children.

Families, including surviving children, will be invited to contribute to reviews unless there is a strong reason not to. Steps will be taken to sensitively manage their expectations and ensure they understand how they are going to be involved.

Practitioners will be fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

All participants in the review process will be asked to declare any potential conflicts of interest and will be expected to sign, and adhere to, a confidentiality agreement.

Strategic Leadership and Governance

The Case Review subgroup 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 or alternative learning reviews. This will include monitoring case progression, quality assurance and publication of final reports, and ensuring effective oversight of the implementation of learning.

All decisions related to the commissioning and publication of local Child Safeguarding Practice Reviews will be notified to the national Child Safeguarding Practice Review Panel, the Department for Education and Ofsted.[6]

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[4] 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).

[5] 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.

[6] 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.

Information Sharing

Information sharing is essential to safeguard and promote the welfare of children and young people. Effective Child Safeguarding Practice Reviews are equally dependent on all relevant partners sharing the information they hold about the case and associated professional practice.

The Safeguarding Partners have the formal authority to request information to support both national and local Child Safeguarding Practice Reviews and the power to take legal action if information is withheld without good reason.

All agencies will be expected to share relevant information within the timescales requested. This may, when necessary, include sharing information without consent (such as where there is an ongoing police investigation). This includes information about parents, guardians and other family members as well as the child(ren) who are subject of the review.

Where a request is for health records this applies to all records of NHS commissioned care whether provided under the NHS or in the independent or voluntary sector.

When making requests for information, the Safeguarding Partners will consider their responsibilities under the relevant information law and have regard to guidance provided by the Information Commissioner's Office.

Good practice principles around information sharing will always be followed, particularly around 'how' information is shared. For example, when responding to requests for information, agencies should:

- Identify how much information to share; Distinguish fact from opinion;
- Ensure that they give the right information to the right individual;
- Ensure that they share information securely;
- Where possible, be transparent with the individual, informing them that that the information has been shared (as long as doing so does not create or increase the risk of harm);
- Record all information sharing decisions and reasons in line with organisational procedures.

In the case of any disagreement or failure to comply with a formal information request, the Independent Lead Reviewer or member of an Independent Review Team will refer the issue to the Case Review Subgroup who will seek to resolve this with the strategic Safeguarding Lead for the agency concerned. If a prompt resolution cannot be found, the issue will be escalated to the Safeguarding Partners for formal action.

Timescale for Completion of the Review

Reviews will vary in their breadth and complexity but in all cases learning should be identified and acted upon as quickly as possible. This includes before the review has formally commenced and while it is in progress.

A Rapid Review and decision on all referrals should be made within the timescales outlined in guidance from the National Panel (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. Other learning reviews should be completed more quickly, ideally within three months.

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 request a delay to the review due to involving specific key individuals. Any delays need to be considered by the relevant Case Review Subgroup as soon as they arise. If the delay will prevent the publication of the final report within six months, the National Panel and Secretary of State should be informed and provided with the reason for the delay.

Making a Referral for a Child Safeguarding Practice Review

Agencies should inform the Independent Safeguarding Partnership Service of any serious incident which they think should be considered for a Child Safeguarding Practice Review, using the *Referral Form* (Document 1).

Local authorities have a duty to notify the National Child Safeguarding Practice Review Panel and the Safeguarding Partners **within five working days** if it knows or suspects that a child has been abused or neglected and

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

(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 and Ofsted where a Looked After Child has died, whether or not abuse or neglect is known or suspected.

The duty to notify events to the Panel rests with the local authority. Others who have functions relating to children[7] should inform the safeguarding partners of any incident which they think should be considered for a child safeguarding practice review.

Rapid Review

Rapid Reviews should assemble the facts of the case as quickly as possible in order to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning.

The Rapid Review must be completed within **<u>15 working days</u>** of becoming aware of the incident as outlined in National Panel guidance. A flow chart setting out the key stages and suggested timescales to meet the prescribed submission target is included at the end of this section.

Initial Scoping, Information Sharing and the Securing of Records

All agencies who are known to have had involvement with the subject of the review 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.

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**

[7] This means any person or organisation with statutory or official duties or responsibilities relating to children.

family. More detailed information will be sought if the Rapid Review concludes that the case has the potential to identify national or local learning and a decision is made to progress to a Child Safeguarding Practice Review or alternative Learning Review.

The *Referral and Initial Information Scoping* should be sent out to all relevant agencies **within 2 working days** of receiving the referral. Agencies should prioritise completion of the form and return it **within 5 working days**.

The form should be completed and contain a brief analysis of their agencies involvement with the family. Agencies must not "cut and paste" case notes or chronologies into the form.

If the form is not completed to a reasonable standard and does not contain an analysis of involvement the form will be returned to agencies and they will be asked to recomplete it.

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

Rapid Review Meeting

The date of the Rapid Review meeting should be set as soon as the *Initial Scoping* 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 establish the key events in the child's life and inform the Rapid Review whilst also allowing sufficient time to prepare the necessary documents for the National Panel.

The *Referral Form* and copies of the completed *Initial Information* from relevant agencies will be collated into a single document which should be shared with all those participating in the Rapid Review meeting.

Wherever possible the documentation will be shared with participants in advance of the meeting. However, it is recognised that it may on occasion be necessary to share documentation at the meeting.

The meeting will include representatives from each of the Safeguarding Partners (the CCG, police and local authority) and any other agencies who had significant involvement with the family. It will only be quorate if **at least one representative is present from each of the Safeguarding Partners**.

The Rapid Review meeting should:

- review the facts about the case as presented in the documentation;
- discuss whether any immediate action is needed to ensure children's safety;
- identify immediate learning that can be acted upon and agree how this will be shared. (This may remove the need for further review).
- consider the potential for identifying improvements to safeguard and promote the welfare of children.

Following discussion about the case, each of the three statutory partners (Police, CCG and LA) will get a single vote, to decide whether to undertake a Child Safeguarding Practice Review. If the decision is not to proceed with a formal Child Safeguarding Practice Review, they will vote on whether an alternative form of learning review is

appropriate.

The *Rapid Review Template* should be completed and agreed at this meeting.

Sharing the Outcome of the Rapid Review

Within 2 working days of the Rapid Review meeting, the Independent Safeguarding Partnership Service should send the completed Rapid Review to the National Panel (Mailbox.NationalReviewPanel@education.gov.uk)

Individual agencies should notify their own inspectorate bodies as required.

Review Process

Once the decision has been made that a local Child Safeguarding Practice Review will be undertaken, a Panel will be established on the basis that they had no immediate line management of the case under review. The panel will include, representatives of the three statutory agencies (Local Authority; Police; Clinical Commissioning Group) along with representatives from agencies who had significant involvement with the case and any relevant subject matter experts depending on the case.

The Panel will support the Lead Reviewer scrutinise information provided by agencies. The Panel also provides local context and challenge to the analysis of professional practice and the identification of learning. Where a report is not of the quality expected then the Lead Reviewer and/or Chair of the Panel will make contact with the relevant agency and ask for the report to be revised and resubmitted in a timely manner.

The police representative will be responsible for liaising with the Senior Investigating Officer, Crown Prosecution Service, and for co-ordination of family liaison.

The Panel will set their own meeting schedule and timings appropriate to the case and the methodology. Whilst the frequency and number of meetings may vary, the Panel will in most instances progress through the following three stage process, in order to establish; monitor and finalise the review:

Stage 1 - Establish

The Panel will have responsibilities from the outset to:

- Specify the Terms of Reference
- Set timescales, if not already determined
- Confirm the lead roles such as Chair, Facilitator, Author and the planned methodology to be used
- Links to other interested parties such as the Crown Prosecution Service or Coroner
- Coordinate and compile the available information including chronologies and reports of investigations that may have taken place
- Confirm the agencies and the people involved and affected
- Identify, inform and establish links to any other processes ongoing or planned
- Where required, request that Independent Management Reviews are completed
- Identify any additional reports, information or evidence required
- Agree the nature and extent of expert or legal advice required
- Develop media and communications plans and with appropriate advice, publishing

considerations
- Consider how the child, siblings and/or family can be involved in the review
- Set future panel meeting dates and times

Stage 2 - Monitor

During this phase the following functions are likely to be required of the Panel (with flexibility according to the methodology used and proportionate to the circumstances).

- Maintain links with interested parties and parallel investigations
- Produce a comprehensive chronology that covers that critical period collated from all agencies
- Receive and scrutinise additional reports including IMRs and safeguarding/serious incident investigations
- Cross reference information within the reports, identify any omissions or discrepancies
- Conduct/commission any further enquiries
- Examine and identify relevant action points
- Form a view on practice and procedural issues
- Identify critical points and actions with any key lines of enquiry
- If the methodology requires a workshop or learning event, then this will be planned and delivered
- Develop a framework for the report and consider drafts

Stage 3 - Finalise

During this stage, the members of the panel will discuss and agree the key learning points of the review, the recommendations and actions required; and finalise the report.

Some of this work may be able to be undertaken outside of meetings, in which case panel members must commit to prioritise input and feedback to reports that are circulated within timescales.

On completion, the Overview Report will be presented to the Cambridgeshire and Peterborough Safeguarding Children Partnership Board which will:

- Ensure contributing agencies have the opportunity to confirm the accuracy of facts and interpretation of their involvement in the report
- Confirm the recommendations from the report
- Confirm action plans, which should be endorsed at senior level by each organisation and agree accountability
- Confirm to whom the review or parts of the review are to be made available (decisions on publishing will have been taken before completion of the review)
- Commissioning the dissemination of the review of key findings to interested parties including feedback and debriefing to staff, family members and media
- Confirm the arrangements to ensure that the actions are monitored and updates requested from agencies
- Sign off the action plan when complete

Identifying and Engaging Family Members

The lead agency working with the child/family may be asked to prepare a full and accurate **genogram** to assist the clarification of family relationships and dynamics. This will be shared with other agencies at Panel meetings and will be updated based on any additional information on the family provided by these agencies. The genogram will not be included in the final report however in complex family networks, an anonymised genogram may be included.

Using the information available, 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.

Family members, including surviving children, will be informed of the review and invited to contribute unless there is a strong reason not to do so. The initial planning meeting will discuss family involvement and agree an approach that will sensitively manage their expectations and ensure they understand the process.

Personal contact should be made whenever possible by the most appropriate professional and the family provided with a letter and/or leaflet to explain and introduce the process and Lead Reviewer.

Family engagement will normally be led by the Lead Reviewer so that the family's views can be included alongside the analysis of professional practice.

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.

The family may request sight of the information that has been gathered for the purposes of the review (agencies chronologies/ reports etc.). The partnership work to the principle that this information has been produced for the purposes of conducting a case review. The information (reports/ chronologies) remain the property of the agency that produced them and any requests for disclosure need to be addressed to each individual agency for their consideration. Agencies will consider sharing their information on a case by case basis, thought must be given to the impact of disclosure of information regarding other agencies practice that is contained within their reports.

Parallel Investigations

The case may also be subject to a criminal or coroner's investigation, individual agency or professional body disciplinary procedures, and/or another type of formal review[8]. It is anticipated that a local Child Safeguarding Practice Review will go ahead unless there are clear reasons not to.

Where a Coroners Court requests sight of a case review report or information relating to the review this will be shared in line with Worcestershire County Council and Worcestershire Safeguarding Children Board v HM Coroner for the County of Worcestershire [2013]

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

Under Working Together 2018 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 maximise learning.

Agencies should be aware that a request may be made by the Police or Court for chronologies/ reports 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.

Legal Advice

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

Timetable

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

Appointing the Lead Reviewer and Review Team

A Lead Reviewer will be appointed to manage the review process, chair meetings of the Review Team, facilitate the Learning Workshops and author the final report.

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

Methodology

Working Together 2018 does not specify the methodology that should be used in local Child Safeguarding Practice Reviews but there is an explicit expectation that '*principles of the systems methodology recommended by the Munro Report*' will be '*taken into account*' by the Safeguarding Partners when agreeing the method by which the review will be conducted.

Each case will, however, be examined individually and the methodology may be adapted to meet the specific needs of the case, to ensure a proportionate response, and to maximise learning to improve both frontline safeguarding practice and organisational structures. The Safeguarding Partners may agree to use a different methodology.

Agency Action and Expectations

All agencies which provided services to the family during the time period specified in the Terms of Reference will be formally requested to participate in the review process. The extent

of agency engagement will be dependent on the type of review commissioned, the specific Terms of Reference and methodology chosen.

Each organisation should have an identified Safeguarding Lead to act as a single point of contact for the co-ordination and support of the review process.

Agencies should ensure that all requests for information are acted upon in a timely 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.

Information Collection and Collation

Using the chronologies and/or analysis in the Information Reports, the Panel and IMR Authors will discuss the case in detail and develop the **Key Themes.** The key themes should identify issues of practice that have emerged within the case which can (i) be transposed into working with families more generally and (ii) give insight into the systems which operate formally or informally within safeguarding practice.

Practitioner Feedback Event

Practitioners who have participated in the review will also be invited to a feedback session towards the end of the process. The Lead Reviewer / Review Team will share the learning that has been identified and provide practitioners with an opportunity to comment on the accuracy of the analysis before the review report is finalised. Practitioners may also be invited to consider how learning can be transposed into practice on a day to day basis and practical issues around the implementation of possible improvements.

The Overview Report

The Lead Reviewer will normally draft the formal report with publication in mind

Reports should meet any requirements specified in the agreed Terms of Reference for the review and, as a minimum, must include:

- a summary of any recommended improvements to be made by persons in the area to safeguard and promote the welfare of children
- an analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report

Reports should also 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;
- a summary of why relevant decisions by professionals were taken;
- a critique of how agencies worked together and any shortcomings in this; whether any shortcomings identified are features of practice in general;
- what would need to be done differently to prevent harm occurring to a child in similar circumstances;
- examples of good practice; and,
- what needs to happen to ensure that agencies learn from this case.

Any recommendations made should be clear on what is required of relevant agencies and others collectively and individually, and by when, and focussed on improving outcomes for children.

Reports should be written in a way that avoids harming the welfare of any children or adults in the case. Information should be appropriately anonymised and very intimate and personal detail of the family's life should be kept to a minimum to reduce the sensitivity of publication.

The Case Review Panel will be responsible for ensuring the draft report has met the agreed terms of reference, is succinct and focused on improving local safeguarding arrangements.

The final report should be formally approved by the Cambridgeshire and Peterborough Safeguarding Children Partnership Board.

Publication

The Safeguarding Partners are required to publish the reports of local Child Safeguarding Practice Reviews, unless they consider it inappropriate to do so.[9]

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

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

The wishes of the child's family will be considered as part of the publication and media planning. The proposed publication arrangements will then be discussed with the family and appropriate steps will be taken to minimise the disruption and distress that any media attention surrounding the publication may cause to family and friends.

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

A central point of contact for media enquiries should be identified. This individual can co-ordinate media enquiries during the publication phase and ensure effective liaison is maintained with each organisation's strategic and press leads.

The Safeguarding Partners must send a copy of the full report to the National Panel, Ofsted and to the Secretary of State no later than **seven working days before the date of publication**. Reports should be submitted electronically to:

Mailbox.NationalReviewPanel@education.gov.uk

SCR.SIN@ofsted.gov.uk

Mailbox.CPOD@education.gov.uk

Published reports will always include the name of the reviewer(s) and will be made available

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

to read and download from the Cambridgeshire and Peterborough Safeguarding Partnership Board website. Reports will be publically available for **at least one year** and archived reports will be available on request from the Safeguarding Partners.

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

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

The Panel will consider at every meeting whether any immediate single or multi-agency action is required to respond to emerging issues identified through the review process[10]. 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 Panel will consider what information is shared and whether this will have an impact on family members or any parallel investigations.

Disseminating and Sharing Learning from the Review

The Case Review Subgroup, or Training Subgroup, will be responsible for ensuring the identified improvements are implemented locally, including the way in which organisations and agencies work together.

A clear plan for disseminating and sharing the learning from the review with all relevant agencies will be developed. This may include organising single or multi-agency meetings, or producing briefing notes on the lessons learned for use in agency team meetings and/or supervision sessions.

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

Monitoring Progress

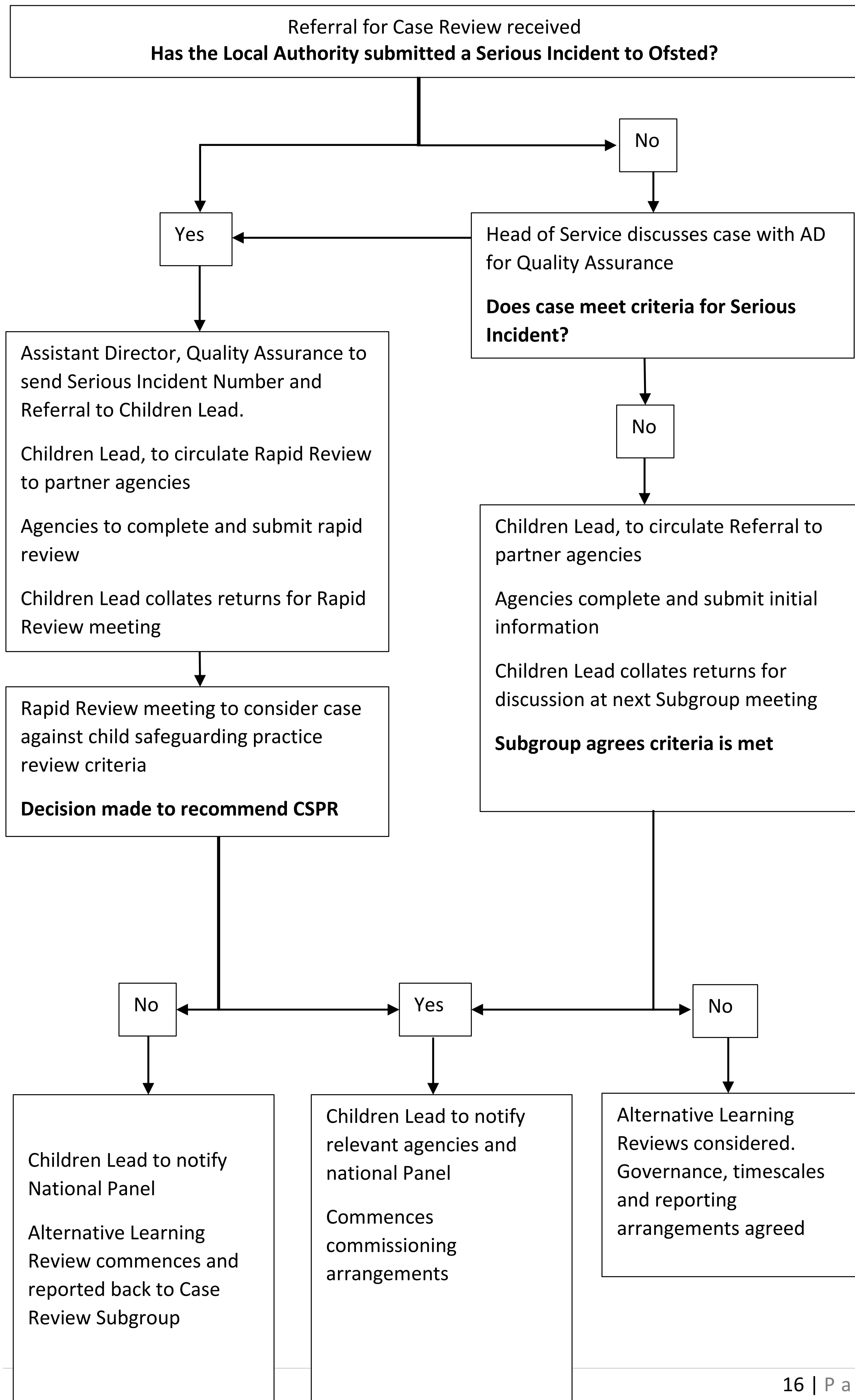
The Case Review subgroup will regularly monitor progress on the implementation of recommended improvements, and will follow up actions to ensure improvement is sustained.

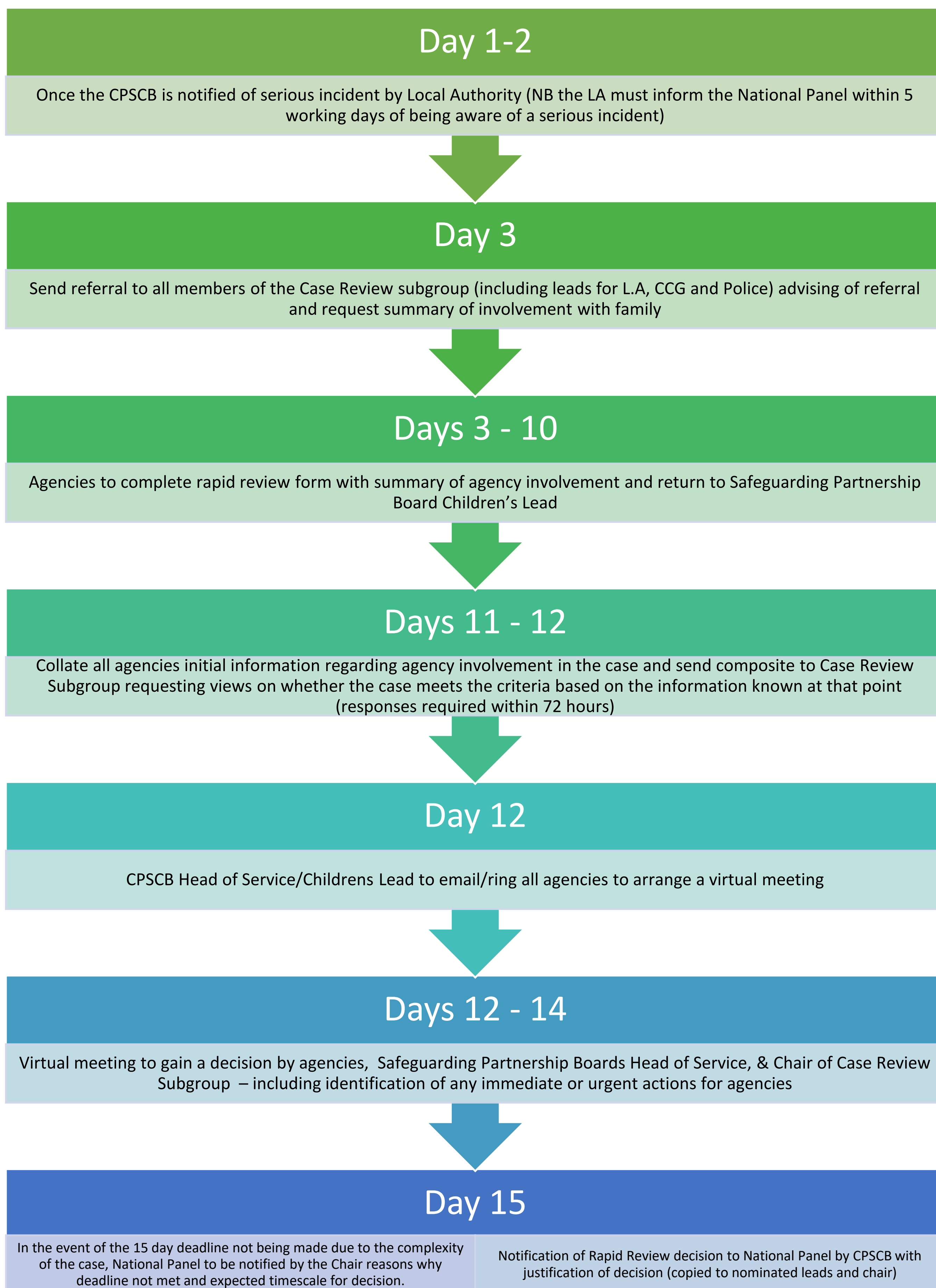
Taking into Account Learning from National Reviews

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

[10] This ensures compliance with *Working Together 2018* which requires that *'every effort should be made, both before the review and while it is in progress to (i) capture points from the case about improvements needed, and (ii) take correction action and disseminate learning.'*

Appendix 1 – CSPR Referral Process Flowchart




Day 1-2
Once the CPSCB is notified of serious incident by Local Authority (NB the LA must inform the National Panel within 5 working days of being aware of a serious incident)
Day 3
Send referral to all members of the Case Review subgroup (including leads for L.A, CCG and Police) advising of referral and request summary of involvement with family
Days 3 - 10
Agencies to complete rapid review form with summary of agency involvement and return to Safeguarding Partnership Board Children's Lead
Days 11 - 12
Collate all agencies initial information regarding agency involvement in the case and send composite to Case Review Subgroup requesting views on whether the case meets the criteria based on the information known at that point (responses required within 72 hours)
Day 12
CPSCB Head of Service/Childrens Lead to email/ring all agencies to arrange a virtual meeting
Days 12 - 14
Virtual meeting to gain a decision by agencies, Safeguarding Partnership Boards Head of Service, & Chair of Case Review Subgroup – including identification of any immediate or urgent actions for agencies
Day 15
In the event of the 15 day deadline not being made due to the complexity of the case, National Panel to be notified by the Chair reasons why deadline not met and expected timescale for decision.
Notification of Rapid Review decision to National Panel by CPSCB with justification of decision (copied to nominated leads and chair)

Appendix 2 - Overview of Parallel Statutory Reviews

Effective local liaison is required between Multi-Agency Safeguarding Arrangements, Adult Safeguarding Partnership 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;

Safeguarding Adult Review

The Cambridgeshire and Peterborough Safeguarding Adults Partnership Board oversees the commissioning of Safeguarding Adult Reviews (SAR). Where a case may meet the criteria for a SAR or CSPR liaison will take place between the Adult and Children Safeguarding Partnership Board's to discuss primacy and agree the way forward. The majority of cases focus on transition to adulthood and the potential to improve inter-agency working.

There are three broad circumstances under which the Care Act statutory guidance considers a SAR may take place. The guidance makes a distinction between those circumstances where the SAB **must** or **may** arrange a SAR.

The SAB **must** arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

1. There is reasonable cause for concern about the SAB, members of it or other persons with relevant functions worked together to safeguard the adult; **and**
2. **Either**

   a) The adult has died and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died

   Or

   b) The adult is still alive and the SAB knows or suspects that the adult has experienced serious abuse or neglect

A SAB **may** also arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs). SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

Domestic Homicide Review

Domestic Homicide Reviews (DHR) are commissioned by Community Safety Partnerships and overseen by the Home Office.

Section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act)1. The Act states:

A "domestic homicide review" (DHR) means a 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) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
b) a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

A DHR is undertaken to :

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice. (Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016; p6))

The Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) states:

'It should be noted that, when victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for child Serious Case Reviews, Safeguarding Adults Review and a Domestic Homicide Review. Consideration should be given to how these reviews can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case – for example, considering whether some or all aspects of the reviews can be commissioned jointly so as to reduce duplication of work for the organisations involved and provide an improved experience for families, subject to the final shape of the review meeting the requirements of both as set out in the statutory guidance.'

For further information, see the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) Home Office.

DHR may also run alongside (in parallel) to any potential SAR or CSPR.

Multi-Agency Public Protection Arrangements – Serious Case Review

The purpose of the MAPPA SCR is to examine whether the MAPP arrangements were effectively applied and whether the agencies worked together to do all they reasonably could to manage effectively the risk of further offending in the community.

The chair of the MAPPA SMB has the responsibility to decide whether a case requires a MAPPA Serious Case Review (SCR).

It is a MAPPA SMB responsibility to commission a MAPPA SCR when the mandatory criteria have been met.

The SMB must commission a MAPPA SCR **if both of the following conditions apply**.

- The MAPPA offender (in any category) was being managed at level 2 or 3 when the offence was committed or at any time in the 28 days before the offence was committed.
- The offence is murder, attempted murder, manslaughter, rape, or attempted rape.

There will be other Serious Further Offences that may trigger a MAPPA SCR. It is difficult to prescribe discretionary criteria as much will depend on the circumstances of the particular case and whether there has been a significant breach of the MAPPA Guidance, but MAPPA SCRs **might be commissioned when**:

- A level 1 offender is charged with murder, manslaughter, rape or an attempt to commit murder or rape
- An offender being managed at any level is charged with a serious offence listed in PI 10/2011 or
- It would otherwise be in the public interest to undertake a review, e.g. following an offence which results in serious physical or psychological harm to a child or vulnerable adult but which is not an offence listed in PI 10/2011

However, as a review of the lead agency's management of the case will be conducted under these circumstances, careful consideration should be given to whether any value would be gained by conducting a MAPPA SCR for level 1 cases. This is especially relevant if cases have never been managed at level 2 or 3.

For further information, see MAPPA Guidance (2012) Ministry of Justice.

Other reviews may be triggered by the re-offending, for example:

- Serious Case Reviews for Children - set out in Chapter 8 of Working Together to Safeguard Children (2010)
- Domestic Homicide Reviews (Domestic Violence, Crime and Victims Act 2004).

These reviews do not specifically look at how agencies worked together under MAPPA but such a review may also be triggered by the offender's re-offending. To avoid duplication and any misunderstanding, the MAPPA SMB must have in place a system of identifying whether any other review is taking place and of notifying other agencies when a MAPPA SCR is taking place.

Serious Incidents

Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation’s ability to deliver ongoing healthcare.

Serious Incidents in the NHS include:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
    - Unexpected or avoidable death8 of one or more people. This includes –
        - suicide/self-inflicted death; and
        - homicide by a person in receipt of mental health care within the recent past (see Appendix 1);
    - Unexpected or avoidable injury to one or more people that has resulted in serious harm;
    - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:—
        - the death of the service user; or
        - serious harm;
    - Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self neglect, domestic abuse, human trafficking and modern day slavery where:
        - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
        - where abuse occurred during the provision of NHS-funded care.

This includes abuse that resulted in (or was identified through) a Child Safeguarding Practice Review (CSPR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident .

- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death;
- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
    - Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues;
    - Property damage;
    - Security breach/concern;
    - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
    - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
    - Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
    - Activation of Major Incident Plan (by provider, commissioner or relevant agency)
- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

Healthcare providers must contribute towards Child Safeguarding Practice Reviews and Safeguarding Adult Reviews (and enquiries) as required to do so by the Local Safeguarding Partnership Boards. Where it is indicated that a serious incident within healthcare has occurred, the necessary declaration must be made.

Whilst the Local Authority will lead CSPRs, SARs and initiate Safeguarding Enquiries, healthcare must be able to gain assurance that, if a problem is identified, appropriate measures will be undertaken to protect individuals that remain at risk and ultimately to identify the contributory factors and the fundamental issues (in a timely and proportionate way) to minimise the risk of further harm and/or recurrence.

The interface between the serious incident process and local safeguarding procedures must therefore be articulated in the local multi-agency safeguarding policies and protocols. Providers and commissioners must liaise regularly with the local authority safeguarding lead to ensure that there is a coherent multi-agency approach to investigating and responding to safeguarding concerns, which is agreed by relevant partners. Partners should develop a memorandum of understanding to support partnership working wherever possible.

For further information, see Serious Incident Framework Supporting learning to prevent recurrence NHS England.

Independent Investigations for Mental Health Homicides

NHS England are responsible for commissioning an independent investigation of mental health care related homicides when a homicide has been committed by a person who is, or has been, subject to a care programme approach, or is under the care of specialist mental health services, in the past 6 months prior to the event.

The purpose of an independent investigation is to review thoroughly the care and treatment received by the patient so that the NHS can:

- Be clear about what – if anything – went wrong with the care of the patient
- Minimise the possibility of a reoccurrence of similar events
- Make recommendations for the delivery of health services in the future

An independent investigation is carried out separately from any police, legal and Coroner's proceedings. It is done by an independent, expert organisation, which is given access to all the information and reports about the individual patient's care and treatment (within the usual patient confidentiality rules), and who can also request interviews with any NHS staff involved.

Appendix 3 - Models of reviewing cases

The process for undertaking Case Reviews should be determined locally according to the specific circumstances of individual cases. The most appropriate methodology will normally be that which provides the best opportunity to learn; however, it will be determined by, and be proportionate to, the specific circumstances and the scale of the situation.

Examples of different types of methodologies include:

Traditional Model

This methodology, is considered a traditional model, it was often used for serious case reviews. Typical features include:

- Appointment of a panel, including a Chair (usually independent) and core membership which determines Terms of Reference and oversees process
- Independent report author
- Integrated chronology of events
- Involved agencies produce Individual Management Reports, outlining involvement and key issues
- Overview report with analysis, lessons learnt and recommendations
- Relevant agencies produce action plans in response to the lessons learnt

Individual Management Reviews

Individual Management Reviews (IMRs) and Agency Reports are a means of enabling organisations to reflect and critically analyse their involvement, to identify good practice and areas where systems, processes or individual and organisational practice could be enhanced. They are key learning tools used in several methodologies and other similar reviews such as DHRs and SARs. They can be used in a multi or single agency environment.

It is important that individuals who are asked to undertake IMRs have the relevant skills and sufficient independence from the case being reviewed.

Where it is decided that IMRs are required:

- The SAR Panel should write to the Chief Officer of the organisations involved, providing a template for an IMR
- Organisational reports should be prepared by a senior officer and should provide a critical analysis of the organisation's management of the case and identify the lessons learnt and actions taken or to be taken
- In the case of NHS organisations already completing a Serious Incident Investigation the information produced such as a report, chronology, findings and an action plan should be transferred to the IMR document, within the scope of the terms of reference agreed
- Individual Management Reviews must be signed off by the Chief Officer of each organisation

Multi-Agency Chronology

Chronologies are important tools particularly when combined across organisations. This enables a group of organisations to identify gaps in specific areas such as communication, decision making and risk assessment.

Many of the methodologies outlined utilise chronologies within them, however, they can be used in isolation to achieve an overview of a case fairly simply, which can assist in assuring or developing multi-agency working.

In this approach each agency produces a single chronology of involvement, over the period that has been agreed as relevant to the investigation or review. They may also be asked to provide chronologies relating to more than one person of interest in the case.

Where chronologies are used, all relevant agencies will be asked to complete a Chronology of their agency's involvement, over the period that has been agreed as relevant to the review, this may involve more than one person of interest relating to the case.

They may also be asked to include a chronology of any organisational changes which may have impacted on frontline practice during the same period.

How to Complete a Chronology and What is a Key Event Chronology?

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

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

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

· Contacts or referrals about the child / young person / family;

· Assessments undertaken;

· Strategy Discussions

· Meetings and Child Protection Conferences

Child Protection enquiries and Section 47 investigations;

· Non-accidental injury and significant injury or neglect events;

· Attendance / admittance to hospital;

· Births, deaths, serious illness of adults and children and young people in the family;

· House moves;

· Changes in family composition, including new partners, separations, non-family members moving into family home;

· Criminal proceedings and outcomes;

· Civil proceedings involving the family;

· Change in school and school exclusions;

· Change in GP;

· Self-referrals and any referrals to other agencies / teams;

· Court proceedings and changes in legal status, including periods when a child / young

person became looked after by the local authority;

· Police logs detailing relevant incidents at family home or in relation to family members, such as reported incidents of domestic abuse, drunken / anti-social behaviour;

· Child / young person's absconding behaviour / missing from home;

· Attempted suicide or overdose of child / young person or family member;

· Specific support offered to family;

· Events showing capacity of family to work in partnership and engage with professionals;

· Frequent presence of unknown adults;

· Any event in the child's life deemed to have a significant effect on them, such as separation from main carer leading to poor attachment.

Chronologies will be combined to produce an **Integrated Chronology**. This will often be colour coded to facilitate an 'at a glance' overview of agency involvement. This enables a review in determining whether there appears to be grounds for further investigation or potential for learning through more detailed examination and discussion in a multi-agency workshop.

Reflective Learning Workshop

Reflective Learning Workshops provide a forum for frontline professionals and their line managers 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 to identify important multi-agency learning.

The Panel will need to ensure it has a full list of appropriate professionals and line managers to invite to the Learning Workshop. This will usually be requested alongside the Chronology and/or Information Report.

To maximise learning all agencies are expected to ensure that appropriate staff attend the workshop. However, it is preferable that only those who have had some form of direct operational involvement with the child and family should attend. They can be supported by their manager or a colleague.

Invitations to *Reflective Learning Workshop* will be sent to all participants giving plenty of notice. This will be accompanied by a short briefing which explains the purpose of the event and the importance of attending.

The Lead Reviewer will normally facilitate the Reflective Learning Workshop, supported by members of the Panel and/or the Independent Safeguarding Partnership Service.

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;[11]

- 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; and
- any examples of good practice;
- the learning from the case and actions that should be taken to better safeguard children in the future.

Within these discussions it is essential that all actions and decisions (or lack of them) by professionals are viewed within the context of the information available at the time and system in which they were working.

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

Where an individual with important information to contribute to the review is unable to participate, arrangements may be made to facilitate a conversation with the Lead Reviewer to enable them to contribute to the learning.

Peer Review Approach

Peer Led Reviews provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.

Although peer reviews tend to be wholly undertaken by one external team, there can be flexibility within this option regarding the balance of peer team to maximise identified expertise and increase viability. They can be developed as part of regional reciprocal arrangements which identify and utilise skills and enhance reflective practice. Such reviews can be cost effective and spread learning. Likewise, there can be flexibility regarding the exact methodology to be adopted in order to achieve the desired outcomes of the review.

Root Cause Analysis

Root Cause Analysis (RCA) is a technique which can be used to uncover the underlying causes of an incident. It looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened. It is designed to identify the sequence of events working back from the incident itself and identifies a range of factors which contributed to the incident.

This allows the real causes and contributory factors to be identified so that the relevant organisations can learn and put remedial actions in place.

Significant Event Analysis

Significant Event Analysis (SEA) brings together managers and/or practitioners to consider significant events within a case and analyse what went well and what could have been done differently. Its focus is on learning which can lead to future improvements and it results in an

[11] As outlined under section 7, this is an important requirement of *Working Together 2018* as well as good practice in child safeguarding practice reviews.

action plan with recommendations for learning and development. Staff are brought together in a facilitated team approach.

This methodology has been used for many years in General Practice and in other areas of the NHS. The adult at risk is not involved in SEAs, however, the findings may instigate further review or investigation which should involve them.

Appendix 4 - Media strategy for response to serious incidents led by Safeguarding Board

In the event of a serious incident, the Safeguarding Partnership Board will have a single initial point of contact for the media which will be the Communications Team at the Local Authority.

Members of the Board should only talk to the media after having first cleared this with the local authority's Communications Team.

Anyone speaking on behalf of the Safeguarding Partnership Board must ensure that the media knows who they are representing.

Public and media interest

It is the responsibility of designated senior managers in each agency, alongside the Chair of the Safeguarding Partnership Board, to anticipate public and media interest in the death or serious injury of a child or adult at risk, or in the investigation of organised abuse under the umbrella of the Safeguarding Board safeguarding procedures.

The chair, together with the designated senior managers in liaison with their press offices, must consult to formulate and agree a strategy for managing public information and make the necessary and timely arrangements for any media activity. When agreeing a strategy for managing public information consideration must be given to the following:

- The need to maintain confidentiality in respect of personal information contained within reports on the child, family members and others;
- The accountability of public services and the importance of maintaining public confidence in the process of internal review;
- The need to secure full and open participation from the different agencies and professionals involved;
- The responsibility to provide relevant information to those with a legitimate interest;
- The constraints on sharing information when criminal proceedings are outstanding, in that access to the contents of information may not be within the control of Safeguarding Partnership Board.
- It is the duty of senior managers to ensure that all staff undertaking enquiries are aware of the agreed strategy and response to approaches by the public and media representatives, and are enabled to proceed with their work without excessive public pressure and exposure.

Specific media enquiries

A dialogue with key contacts will be established to determine which organisation will take lead responsibility for responding to media enquiries relating to any specific event. This initial dialogue will establish which matters, if any, will be handled collectively by the board and which will be handled by individual board partners.

Ongoing responsibility for co-ordinating this activity will remain with the local authority Communications Team, except where the key contacts agree that the press office of another board partner will take the lead in a particular case. The Head of Service for the Cambridgeshire and Safeguarding Partnership Board will be kept informed of all actions undertaken and will be sent a copy of all communication with the media for inclusion in the audit trail.

Child Safeguarding Practice Reviews (CSPR) / Safeguarding Adult Reviews (SAR)

It is the responsibility of the Chair of the Safeguarding Partnership Board to alert the relevant local authority's Communications Team when an CSPR or SAR is underway and to keep them informed of its progress.

Appendix 5 - Media Alert In Relation To a Serious Incident Involving a Child or Young Person

In the event of a media alert in relation to a serious incident involving a child or young person, the media lead of the partner organisation receiving the information should alert the Local Authority's Communications Team

The local authority's Communications Team will then alert the Chair of the Safeguarding Board and communications leads for all relevant partner agencies.

All communications leads to inform operation lead in their own agency.

A meeting of the key media leads will be convened as soon as possible. If this is not possible, media responses will be approved with the Safeguarding Board Chair and the media leads of the key organisations.