Safeguarding Children Partnership
LEICESTERSHIRE & RUTLAND

Leicester Safeguarding Children Partnership
WORKING TOGETHER TO KEEP CHILDREN SAFE

Local Child Safeguarding Practice Reviews

Framework and Practice Guidance

V3.0

2025

Contents

Who is the Guidance for?

This practice guidance should be read by local Safeguarding Partners, and all agencies involved in the Multi-Agency Safeguarding Arrangements, which replaced the Local Safeguarding Children Boards (LSCBs) in 2019. The guidance is particularly aimed at those involved in undertaking or contributing to Local Child Safeguarding Practice Reviews (LCSPRs), such as Reviewers, Case Review Panel members, those providing information reports on behalf of their agency/organisation as well as those responsible for quality assuring and embedding the learning from the review process.

About this Guidance

This guidance provides Multi-Agency Safeguarding Arrangements across Leicester, Leicestershire & Rutland with a framework for the commissioning and dissemination of 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*.

1. Introduction and Context

1.1 Introduction

1.1.1 The Children and Social Work Act 2017 introduced a legal framework in respect of local safeguarding arrangements for children. Responsibility for how a system learns lessons from serious child safeguarding incidents rests at a national level with the Child Safeguarding Practice Review Panel and at a local level with the three Safeguarding Partners (Integrated Care Boards[1], Police and Local Authorities) and other partner agencies. They will need to consider whether to conduct a Local Child Safeguarding Practice Review in cases where abuse or neglect of a child is known or suspected, and the child has died or been seriously harmed.

1.1.2 This guidance outlines a shared Leicester, Leicestershire and Rutland process for deciding on and commissioning Local Child Safeguarding Practice Reviews in their area. This makes real the local commitment to an improving and learning system, determined to make best use of resources (human and financial) in the best interests of children and families. A shared approach across the sub region:

- reduces the burden on agencies whose work covers more than one Local Authority area as staff only need to understand and work to one set of guidance and
- allows practitioners from across the region to provide peer support to those outside their area as everyone is working to the same framework and guidance.

1.1.3 This guidance provides practitioners 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 2023.* It also outlines responsibilities for key people at every stage of the process and references template documents and letters available for use.

1.1.4 There are some local processes which differ between the Leicester Safeguarding Children Partnership (LSCP) and the Leicestershire & Rutland Safeguarding Children Partnership (LRSCP). To allow for this there is flexibility to use, adapt and amend supporting document

[1] Integrated Care Boards (ICBs) became legal entities as of 01.07.22, replacing Clinical Commissioning Groups (CCGs).

templates, depending on the needs of the individual Safeguarding Partnership and individual reviews.

1.2 Purpose of Local Child Safeguarding Practice Reviews

1.2.1 The purpose of a Local Child Safeguarding Practice Review is to explore how practice can be improved through changes to the system itself. Reviews should seek to understand both why mistakes were made and to comprehend whether mistakes made on one case frequently happen elsewhere and to understand why.[2]

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 will not be used in this way. Nevertheless, where reviews identify 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
- the child has died or been seriously harmed.

1.3.2 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. This is not an exhaustive list."[3]

1.3.3 *Working Together 2023* advises that "When making decisions, judgement 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."[4]

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

1.3.5 *Working Together 2023* states that "The local authority must notify the Secretary of State for Education, and Ofsted of the death of a looked after child. The local authority should also notify the Secretary of State for Education and Ofsted of the death of a care leaver up to and including the age of 24. This should be notified via the Child Safeguarding Online Notification System. The death of a care leaver does not require a rapid review or local child safeguarding practice review. However, safeguarding partners must consider whether the criteria for a serious incident have been met and respond accordingly, in the event the deceased care leaver was under the age of 18. If local partners think that learning can be gained from the death of a looked after child or care leaver in circumstances where those criteria do not apply, they may wish to undertake a local child safeguarding practice review."[5]

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[2] This definition is taken from the Practice Guidance issued by the National Child Safeguarding Practice Review Panel on 5 April 2019.
[3] "Working Together to Safeguard Children 2023: A guide to multi-agency working to help, protect and promote the welfare of children", December 2023, page 132, paragraphs 328-329.
[4] Working Together 2023, page 132, paragraph 329.
[5] Working Together 2023, page 133, paragraphs 331-332.

1.4 Criteria for a Local Child Safeguarding Practice Review

1.4.1 Safeguarding Partners and other partner agencies, as part of the Case Review Group, are required[6] 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 the panel has considered and has concluded a local review may be more appropriate.[7]

1.4.2 They should also **have regard to** circumstances where:

- they have cause for concern about the actions of a single agency
- there has been no agency involvement, and this gives them cause for concern;
- more than one Local Authority, Police area or Integrated Care Board is involved, including in cases where families have moved around
- the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.[8]

1.4.3 *Working Together 2023* highlights that meeting the criteria does not mean a Local Child Safeguarding Practice Review must automatically be undertaken.[9] 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).

1.4.4 Safeguarding Partners and other partner agencies should make sure there is a clear rationale for completing a Local Child Safeguarding Practice Review. Where a Rapid Review has been undertaken (see section 4.2), it is important that Safeguarding Partners and other partner agencies ensure that the process for undertaking a Local Child Safeguarding Practice Review is a clear 'step higher' than a Rapid Review, building on a Rapid Review, and that the learning for practice is more distinctive.[10]

1.4.5 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' incidents".[11]

[6] By the Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018.
[7] Working Together 2023, page 135, paragraph 342.
[8] Working Together 2023, page 136, paragraph 342. 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.
[9] Working Together 2023, page 135, paragraph 339.
[10] This approach is proposed in the Child Safeguarding Practice Review Panel's Annual Report 2021: Patterns in practice, key messages and 2022 work programme (December 2022).
[11] Working Together 2023, page 134, paragraph 338.

1.4.6 Where the decision made is not to proceed with a Local Child Safeguarding Practice Review, the Safeguarding Partners and other partner agencies will consider whether there are other learning processes that will bring forward improvements.

1.5 Approach and Principles

1.5.1 The Safeguarding Partners have agreed that the approach will be 'systems based'. Each case will, however, be examined individually to determine the most appropriate methodology to identify and maximise learning.

1.5.2 All areas will conduct Local Child Safeguarding Practice Reviews in line with good practice and the principles of the systems methodology recommended by the Munro Report.[12] This includes the advice outlined in *Working Together 2023* and its predecessor documents as well as the good practice principles described in the Social Care Institute for Excellence (SCIE) / NSPCC 'Quality Markers'.[13]

1.5.3 Decisions on whether to undertake a review will be made transparently and the rationale shared with all relevant partners, including families as appropriate.

1.5.4 The child will always be placed at the centre of the process.

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, including the racial, ethnic and cultural background of the child and their family, and other characteristics such as age, gender, disability and sexuality, and explicitly discusses how these characteristics shaped a family's and child's lives, experiences, and views, and how practitioners and services responded to them;
- considers and analyses frontline practice as well as organisational structures and learning;
- establishes the reasons why events occurred as they did;
- considers why actions and decisions made sense at the time;
- reaches recommendations 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 will be expected to adhere to confidentiality. This will be a standard agenda item at all case specific meetings.

1.6 Strategic Leadership and Governance

1.6.1 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

[12] 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).

[13] 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.

reports and embedding learning. Safeguarding Partners should take into consideration advice and guidance provided by the national Child Safeguarding Practice Review Panel.

1.6.2 The two Safeguarding Children Partnerships in Leicester and Leicestershire & Rutland have Case Review Groups (CRGs) 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 when Local Authority notifications of serious incidents are made to the national Child Safeguarding Practice Review Panel. They will also consider other cases referred to them by partner agencies and will take responsibility for commissioning and overseeing any resulting 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 Child Safeguarding Practice Review Panel.[14]

2. Information Sharing

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

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

2.1.3 All agencies will be expected to share relevant information within the timescales requested. This may, when necessary, include sharing information without consent. 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 and other partner agencies 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;

[14] 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.

- 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.

2.1.7 In the case of any disagreement or failure to comply with a formal information request, the Reviewer or a Case Review Panel member will refer the issue to the Case 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 Safeguarding Partners 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 Child Safeguarding Practice Review Panel (currently **within 15 working days**) and Local Child Safeguarding Practice Reviews should be completed no later than **six months** from the date of the decision to initiate a review and more quickly if possible.

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 Case Review Group as soon as they arise. If the delay will prevent the publication of the final report within six months, the national Child Safeguarding Practice Review Panel and Secretary of State should be informed and provided with the reason for the delay.

4. Deciding whether to convene a Local Child Safeguarding Practice Review

4.1 Notification and Referral

4.1.1 Agencies should inform the relevant designated single point of contact for the Safeguarding Children Partnership of any serious incident which they think should be considered for a Local Child Safeguarding Practice Review, using the Referral Form. For Leicester cases, this is the Leicester Safeguarding Boards Office and for Leicestershire & Rutland cases, this is the Leicestershire & Rutland Safeguarding Partnerships Business Office.

4.1.2 Local Authorities have a separate duty to:

- notify the national Child Safeguarding Practice Review Panel if they know or suspect that a child has been abused or neglected and the child dies or is seriously harmed in their area (or outside of England while they are normally resident in the Local Authority area);
- notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected.

4.1.3 Where a Local Authority makes a formal notification to the national Child Safeguarding Practice Review Panel, it must always share this with the relevant Safeguarding Children Partnership Business Office.

4.1.4 A notification by the Local Authority to the national Child Safeguarding Practice Review Panel will result in a Rapid Review (see 4.2 below).

4.1.5 There will be instances when a referral is made to the Case Review Group by an agency which does not result in a Rapid Review. For example, in a situation where an agency believes a case should be considered by the Case Review Group for a potential Local Child Safeguarding Practice Review, but it does not meet the criteria for a Local Authority Notification to the national Child Safeguarding Practice Review Panel. The formal Referral Form should be used to make a referral to the Case Review Group in these circumstances.

4.1.6 Where a referral is made by another agency, the Local Authority representative that sits on the Case Review Group will be informed so that they can consider if a notification is required. If it is, the Rapid Review process will be initiated.

4.1.7 Where there is no requirement for a Rapid Review, due to the circumstances described at 4.1.5, the following documents can then be used to assist the Case Review Group with obtaining agency information:

- Information Request Letter
  Should be used to make a request for information to agencies to assist the Case Review Group to discuss potential Local Child Safeguarding Practice Reviews

- Information Request Reply Template
  Is a template for agencies to record information for the Case Review Group meeting

- *Leicester City only* – a chronology template.

4.1.8 The Case Review Group will discuss the case and make a decision if the criteria for a Local Child Safeguarding Practice Review are met. If they are, the national Child Safeguarding Practice Review Panel will be informed and the Local Child Safeguarding Practice Review process will be followed.

4.2 Rapid Reviews (where a Local Authority notification has been made)

4.2.1 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.

4.2.2 The Rapid Review must be completed within the timescales outlined in guidance from the national Child Safeguarding Practice Review Panel (currently **15 working days** of becoming aware of the incident). A flowchart, setting out the key stages and timescales, is included at the end of this section.

4.3 Initial Scoping, Information Sharing and the Securing of Records

4.3.1 All agencies who have had involvement 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, an Information Request Reply Template will be sent out, accompanied by an Information Request Letter. *Leicester City only* will send a chronology template to complete.

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 Local Child Safeguarding Practice Review.

4.3.3 **The Information Request Reply Template should be sent out to all relevant agencies as soon as possible along with an accompanying letter that briefly outlines the notification and explains the purpose of this initial scoping. *In Leicestershire & Rutland only,* in all cases, this should be within 2 working days of receiving the notification.**

4.3.4 Agencies should prioritise completion of the template and return it by the deadline included in the letter.

4.3.5 All agencies should consider if they need to 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.

4.4 Setting the Date of the Rapid Review Meeting

4.4.1 The Case Review Groups meet monthly to oversee learning from serious incidents and the Groups will be well placed to undertake the Rapid Review of new notifications. Where required, the group will convene an extraordinary meeting to undertake the Rapid Review. At present, both Case Review Groups have diarised meetings arranged between the standard monthly meetings. These only take place if a Rapid Review decision is required when the timescales dictate that the case cannot be managed at the planned monthly meetings.

4.4.2 The date of the Rapid Review meeting should be set as soon as the Information Request has been sent out (see flowchart). The Rapid Review meeting should be scheduled **between 7 and 13 working days** of receiving the notification. This will allow for analysis of the submitted agency information 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 Child Safeguarding Practice Review Panel.[15]

4.4.3 *Leicester City Case Review Group only* convene an additional meeting upon receiving a notification where they agree the parameters of their information request and the date of the Rapid Review meeting, if this does not fit into their existing cycle of pre-scheduled meetings.

4.5 Documentation

4.5.1 The following documents may be shared with those attending the Rapid Review meeting:

- a copy of the Combined Summary Report – this is the document used to collect all of the information together and to guide the Rapid Review meeting through the decision-making process
- *in Leicester City only*, a combined chronology.

4.5.2 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.

4.6 The Rapid Review Meeting

4.6.1 The meeting should include representatives from each of the Safeguarding Partners (the Integrated Care Board, Police and Local Authority) and any other relevant agencies. It will

[15] In Leicester City, the information request goes directly to schools. *In Leicester City only*, where school information is required and schools are closed for holiday periods, exceptions are made. In Leicestershire & Rutland, information requests go via the agreed Leicestershire and Rutland Education representatives.

only be quorate if at least three representatives from partner agencies, including at least two of the Safeguarding Partners are present.

4.6.2 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 child(ren)'s and any other vulnerable person'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;
- make a decision if a Local Child Safeguarding Practice Review should be commissioned
    - if the decision is to make a recommendation to proceed with a Local Child Safeguarding Practice Review, the meeting should agree on Key Lines of Enquiry (KLOE)
    - if the decision is to make a recommendation not to proceed with a Local Child Safeguarding Practice Review, because the criteria are not met or because it is deemed that all learning has been derived from the Rapid Review, the meeting will consider if any dissemination of the Rapid Review learning is appropriate.

4.6.3 Sections 2 and 3 of the Combined Summary Report should be completed and agreed at the Rapid Review meeting.

4.7 Independent Advice on Rapid Reviews and Local Child Safeguarding Practice Review decisions

4.7.1 The Independent Scrutineer of the Safeguarding Children Partnership will be sent the information regarding the Rapid Review and should attend the Rapid Review meeting.

4.7.2 Their role in the meeting will be to observe and then, when requested by the Chair of the Case Review Group, provide independent advice (including questions the meeting should consider) regarding:

- The decision as to whether to carry out a Local Child Safeguarding Practice Review
- Key areas to be considered in the review.

4.7.3 This allows the Independent Scrutineer to provide independent advice, being aware of the discussion that has taken place, but not unduly influencing the main consideration of the case by the meeting. It also minimises the need for further communication/discussion about the decision following the meeting.

4.7.4 **If the Independent Scrutineer is not available to attend the meeting,** they should provide their independent advice to the Business Office prior to the meeting regarding:

- Whether to carry out a Local Child Safeguarding Practice Review
- Key areas to be considered in the review / consideration of the case.

4.7.5 The Business Office will then feed this into the meeting when requested. The decision may also then need to be communicated to the Independent Scrutineer after the meeting (plus any rationale from the meeting) for advice regarding the decision made – which could require some further discussion with Safeguarding Partners.

4.8 Sharing the Outcome of the Rapid Review

4.8.1 The relevant SCP Business Office should then send a Rapid Review Report to the national Child Safeguarding Practice Review Panel (Mailbox.NationalReviewPanel@education.gov.uk).

4.8.2 Other agencies (including the agency who made the referral) should also be informed of the outcome of the Rapid Review.

4.8.3 Individual agencies should notify their own inspectorate bodies as required.

4.9 Flowchart of the Process to decide whether to commission a Local Child Safeguarding Practice Review and the associated timescales

Local Authority Notification to the National Panel (Rapid Review)

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Within 2 working days *(timescale applied in Leicestershire & Rutland only)* of notification to the National Panel

- Information Request Letter is sent to agencies along with Information Request Reply Template (and chronology template *in Leicester only*)
- Date set for a Rapid Review meeting (this could be a planned Case Review Group meeting or an extraordinary meeting to undertake a Rapid Review).

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Within 10 working days of notification to the National Panel

- Completed Information Request Reply Template is returned by agencies
- A Combined Rapid Review Summary is shared with those agencies attending the Rapid Review meeting
- The Independent Scrutineer is also sent the summary document for their consideration.

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Between 10 and 13 working days of notification to the National Panel

The Rapid Review meeting will be held to:

- Review the facts about the case as presented in the documentation;
- Discuss whether any immediate action is needed to ensure child(ren)'s and any other vulnerable person'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;
- Make a decision if the criteria for a Local Child Safeguarding Practice Review (LCSPR) are met.

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Between 1 & 2 working days of the Rapid Review meeting

- Undertake any further ratification of the decision by the Independent Scrutineer and/or Safeguarding Partners as local protocols and the specifics of the case require.

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Within 15 working days of notification to the National Panel

- The relevant SCP Business Office should then send a completed Rapid Review Report to the National Panel.

Referral from an Agency (No Rapid Review)

Agency submits a LCSPR referral form to the relevant SCP office (No Local Authority Notification made to the National Panel)

Within <u>one month</u> of receiving the referral

- Share details with the Local Authority Case Review Group representative so they can consider the potential need for notification
- The referral is initially discussed at the first scheduled Case Review Group meeting after the referral has been received
- If it is considered that it might meet the criteria for a Local Child Safeguarding Practice Review (LCSPR), an Information Request Letter is sent to agencies along with Information Request Reply Template (and chronology template *in Leicester only*).

Within <u>two months</u> of receiving the referral

- All agency replies are collated to produce the Combined Rapid Review Summary for the next scheduled Case Review Group meeting
- At the next scheduled Case Review Group meeting, the group considers the case as a potential Local Child Safeguarding Practice Review using the same criteria that a Rapid Review would apply
- If the decision is made that the case meets the criteria for a Local Child Safeguarding Practice Review, the relevant SCP Business Office should then send the completed Combined Summary to the National Panel and the process for conducting a Local Child Safeguarding Practice Review is followed.

5. Agreeing the Scope and Terms of Reference

5.1 Developing the Terms of Reference

5.1.1 The development of the Terms of Reference (TORs) will be dependent on the specific methodology employed to review an individual case. The Case Review Group should have an early input into the Terms of Reference and the Independent Scrutineer may have specific issues they want to include in the Terms of Reference.

5.1.2 If a Case Review Panel is set up to manage the specific review, they will have the responsibility of completing the Terms of Reference at an early stage of their first meeting. In order to do this, they may wish to make use of the Terms of Reference Template. If a Reviewer is commissioned, they will also be involved in the development of the Terms of Reference. Any issues raised by the Case Review Panel or Reviewer that cannot be resolved will be referred to the Case Review Group for a decision.

5.1.3 The Case Review Group will formally agree the scope and Terms of Reference for the review.

5.2 Scoping Period

5.2.1 The scoping 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 abuse or neglect and whether early help interventions could have been beneficial.

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 Case Review Group.

5.4 Methodology

5.4.1 Each case will be examined individually, and the methodology will be adapted to meet the specific needs of the case.

5.4.2 The Terms of Reference will specify the methods of 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 or a combination of these (see Section 8.2).

5.5 Engaging Children and Family Members

5.5.1 Using the information available, and the genogram where available (see Section 7), consideration will be given to which family members are relevant to the review and how the family, siblings and the child (where the review does not involve a death) should be invited to contribute.

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

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

5.6 Parallel Investigations

5.6.1 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.[16] It is anticipated that a Local Child Safeguarding Practice Review will go ahead unless there are clear reasons not to. Identifying and responding to learning in a timely manner is important and supports a more effective review.

5.6.2 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 maximise learning.

5.7 Legal Advice

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

5.8 Timetable

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

6. Appointing the Reviewer and Case Review Panel

6.1 The Reviewer

6.1.1 Dependent on the methodology used to undertake a Local Child Safeguarding Practice Review, a Reviewer may be appointed to manage the review process, chair meetings of the Case Review Panel, facilitate the Learning Workshops and author the final report.

6.2 The Case Review Panel

6.2.1 Where appropriate a small, multi-agency Case Review Panel will be established to oversee each review. This will include a representative from each of the Safeguarding Partners along with representatives of any other multi-agency partners. Other relevant subject matter experts may be included depending on the case.

6.2.2 The Case Review Panel will support the Reviewer in quality assuring agency Information Reports and facilitating Learning Workshops. The Panel will also provide local context and challenge to the analysis of professional practice and the identification of learning.

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.

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

7.1.2 In line with good practice,[17] 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.

7.1.3 Family engagement will be included as a standing item at all Case Review Panel meetings. The Panel will also identify an individual who will take responsibility for co-ordinating communication with family members.

7.2 Identifying the Family Network

7.2.1 The lead agency working with the child/family will usually be asked to prepare a full and accurate genogram to assist the clarification of family relationships and dynamics. This will be shared with other agencies at Panel meetings and in the 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 in the final published report with any names included.

7.3 Making Initial Contact with the Family

7.3.1 Family members, including surviving children, will be informed of the review and invited to contribute unless there is a strong reason not to do so. The initial planning meeting (described under Section 5) will discuss family involvement and agree an approach that will sensitively manage their expectations and ensure they understand the process.

7.3.2 Personal contact should be made whenever possible by the most appropriate practitioner and the family provided with a letter (where required, signed for or hand delivered by an appropriate practitioner such as the social worker) and/or leaflet to explain and introduce the process and Reviewer.

7.4 Conversations with Family Members

7.4.1 Family engagement will normally be led by the 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 practice.

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 Report" will be "taken into account" by the Safeguarding Partners and other partner agencies when agreeing the method by which the review will be conducted.[18]

[17] This includes, but is not limited to, the SCIE / NSPCC Quality Marker 4 on Informing the Family and Quality Marker 12 on Family Involvement.
[18] Working Together 2023, page 139, paragraph 356.

8.1.2 This section describes the systems-based approach. This is consistent with both the guidance in *Working Together 2023* and the principles of the systems methodology recommended by the Munro Report.[19]

8.1.3 Each case will 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. For some cases, the Safeguarding Partners and other partner agencies may agree to use a different methodology.

8.2 Agency Action and Expectations

8.2.1 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.

8.2.2 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.

8.2.3 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.

8.3 Information Collection and Collation

8.3.1 The Terms of Reference will specify the information collection and collation tools that will be used in the review. Information will usually be collected using chronologies and Information Reports.

8.4 Chronologies

8.4.1 Where chronologies are used, all relevant agencies will be asked to complete a chronology of their agency's involvement in relation to significant events that are relevant to the case. They may also be asked to produce a chronology of any organisational changes which may have impacted on frontline practice during the same period. If required, chronologies can include columns to provide analysis of individual events, including if an agency's response to an event was expected practice.

8.4.2 Agencies will be sent a Chronology Template and Accompanying Letter, along with Guidance on Completing the Chronologies.

8.4.3 Individual agency chronologies will be collated to produce a Multi-Agency Chronology.

8.5 Information Reports

8.5.1 Information Reports will be requested from agencies where required in order to analyse the agency's involvement with the child and family and any themes that have emerged. The report should be focused on systems learning and outline any potential learning for the agency and for multi-agency arrangements and should include information about actions already undertaken.

[19] 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.

8.5.2 Agencies will be sent an Information Report Template and Accompanying Letter, along with Guidance on Completing an Information Report.

8.6 Factual Summaries

8.6.1 If an agency / organisation has had contact with a subject of a Local Child Safeguarding Practice Review or their family, but their involvement was limited, and no significant incidents have taken place during their contact or as a result of their contact, they may be asked to complete a Factual Summary. This sets out their agency / organisation's involvement without requiring any analysis of the agency's involvement.

8.7 Quality Assurance of Agency Submissions

8.7.1 The Case Review Panel, chaired by the Reviewer, needs to be satisfied that the appropriate level of information has been provided by each agency and that the analysis provides sufficient insight into the actions undertaken by the agency and possible learning.

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

8.8 Establishing Key Themes

8.8.1 Using the chronologies and/or analysis in the Information Reports, the Panel will discuss the case in detail and develop the key themes for analysis. These should be as few as practicable and focus on core learning. The key themes should identify issues of practice that have emerged within the case which can (i) be transposed into working with families more generally and (ii) give insight into the systems which operate formally or informally within safeguarding practice. Some examples might be "making space and time for children" or "the use of assessments to inform future interventions".

8.8.2 The key themes for analysis may be shared with participants prior to their attendance at the Reflective Learning Workshop (Section 8.9).

8.9 Reflective Learning Workshop

8.9.1 Reflective Learning Workshops provide a forum for practitioners involved in the case 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 Reviewer and Panel to explore factors influencing workers working with the family at the time, their decisions and identify important multi-agency learning.

8.9.2 A Reflective Learning Workshop will not be suitable for all reviews. In some cases, the key individuals who had worked with children and families will have left the agencies that they had been employed by at the time of their involvement with a case.

8.10 Preparing for the Learning Workshop

8.10.1 The Panel will need to ensure it has a list of appropriate practitioners and their Line Managers to invite to the Learning Workshop. This will usually be requested alongside the chronology and/or Information Report.

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

8.10.3 An Invitation to the 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.

8.11 The Structure of the Learning Workshop

8.11.1 The Reflective Learning Workshop will normally be undertaken over half a day, although a more complex case may require an additional half day.

8.11.2 The Reviewer will normally facilitate the Reflective Learning Workshop, supported by members of the Panel.

8.11.3 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;[20]
- 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.

8.11.4 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.

8.11.5 The Reviewer will 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 Reviewer to enable them to contribute to the learning.

9. The Report

9.1 The Report

9.1.1 It is expected that reports will be published so the Reviewer should draft the formal report with publication of the report in mind.

[20] As outlined under section 7, this is an important requirement of Working Together 2023 as well as good practice in Local Child Safeguarding Practice Reviews.

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

- an 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 description of the methods used in completing the review, with sufficient detail to explain what was done and how;
- analysis against the key lines of enquiry;
- a clear picture of the child's daily life;
- analysis of how sensitive practice was to race, ethnicity, religion, culture, gender, disability, sexual orientation and other protected characteristics (as defined in the Equality Act)[21];
- information on direct work with children and families – for example, how often workers from all professional backgrounds met them, how long they spent with them, what they observed, what they talked about, what explanations the families gave and why the workers responded as they did;
- analysis of how direct practice was shaped by context and systems (workloads, availability of other services, training, supervision and team culture);
- a summary of why relevant decisions by practitioners were taken;
- analysis 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;
- the views of the child(ren) and family, unless there are compelling reasons not to do so;
- findings from practitioners' events;
- reference to published research relating to themes and learning identified and consideration of other recent cases in the locality and nationally as comparisons;
- findings which are contextualised with other reports, inspections and audits, to get a broader understanding of practice and organisational challenges;
- what needs to happen to ensure that agencies learn from this case and meaningful learning for the multi-agency partnership; and
- a limited number of focused, realistic recommendations, which can then be translated into specific and achievable action plans ('SMART' plans).[22]

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

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

9.1.5 The final report must be formally approved by the relevant Case Review Group followed by the Safeguarding Children Partnership.

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[21] https://www.equalityhumanrights.com/equality/equality-act-2010/protected-characteristics

[22] This list includes points recommended in the Annual review of local child safeguarding practice reviews (December 2022), commissioned by the Child Safeguarding Practice Review Panel and undertaken by the University of East Anglia and University of Birmingham.
'SMART' – specific, measurable, achievable, realistic and time-bound.

9.2 Developing the Findings and Recommendations

9.2.1 The analysis of the information collected during the review, coupled with the feedback from a Reflective Learning Workshop, should lead to the identification of key learning in the form of specific findings in the report.

9.2.2 These findings may be developed into formal recommendations that will form part of the final report. The Safeguarding Children Partnership may choose to convene a dedicated group to consider the learning and how this can be developed into meaningful actions.

9.2.3 In some cases, the Safeguarding Children Partnership may decide at the outset of a review that the identified findings in the report will be considered by a separate group who will identify what action needs to be taken to address a specific finding.

9.2.4 Whichever approach is taken, the Safeguarding Children Partnership 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 actions are focused on the issues that will make a real difference and, therefore, maximise the opportunity to deliver meaningful change.

9.2.5 In all cases, learning 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.

10. Publication

10.1 Requirements

10.1.1 The Safeguarding Partnership is required to publish the reports of Local Child Safeguarding Practice Reviews, unless they consider it inappropriate to do so.[23]

10.1.2 Publication of SMART multi-agency action plans, arising from the recommendations of the review (or a clear statement of why the partnership does not accept them), should also be considered. These should be published alongside the Local Child Safeguarding Practice Review, for accountability and as a sign of the partnership's commitment to learning and improvement.[24]

10.2 Preparing for Publication

10.2.1 Publication will be considered throughout the review process and media planning will commence as soon as the final draft report has been formally endorsed by the Case Review Group and Safeguarding Children Partnership. Publication planning will include strategic leads from all the agencies involved in the review and their media/communication leads.

10.3 Managing the Impact of Publication

10.3.1 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.

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

[23] If they consider it inappropriate to publish the report, they must publish any information about the improvements that could be made following the review.
[24] As stated in the Child Safeguarding Practice Review Panel's "Annual Report" 2021, page 24, paragraph 6.13.

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 the senior managers from each agency will take responsibility for informing frontline staff of the date of publication and ensuring they have appropriate support.

10.4 Media Strategy

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

10.5 Formal Publication

10.5.1 *Working Together 2023* states that "Safeguarding partners must send a copy of the full report to the panel and to the Secretary of State **no later than seven working days before the date of publication**. Where the safeguarding partners decide only to publish information relating to the improvements to be made following the review, they must also provide a copy of that information to the panel and the Secretary of State within the same timescale. They should also provide the report, or information about improvements, to Ofsted within the same timescale."[25] The Safeguarding Children Partnership must send a copy of the full report to the National Panel, Ofsted and to the Department of Education 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 Safeguarding Children Partnership website, unless these are published anonymously. Reports will be publicly available for **at least one year**. Archived reports will be available on request from the Safeguarding Children Partnership, through the relevant Business Office.

10.5.3 On a case-by-case basis, it will be considered if 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 Purpose

11.1.1 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.

[25] Working Together 2023, page 141, paragraph 364.

11.2 Capturing improvements and Taking Corrective Action while the Review is in Progress

11.2.1 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.[26] 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.

11.3 Disseminating and Sharing Learning from the Review

11.3.1 The relevant 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 will be developed. This may include organising single or multi-agency meetings or producing briefing notes on the lessons learned for use in agency team meetings and/or supervision sessions.

11.3.3 It is the responsibility of the agencies who have participated in the review to ensure their agency recommendations are fully implemented and used to make improvements to their safeguarding children arrangements and information on this and the impact of improvement is reported to the Safeguarding Children Partnership.

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.

11.5 Taking into Account Learning from National Reviews

11.5.1 The Case Review Group of the Safeguarding Children Partnership will also review the learning from all national reviews and consider how it can be applied at a local level.

12. Local involvement in National Reviews

12.1 The Child Safeguarding Practice Review Panel decides whether it is appropriate to commission a National Child Safeguarding Practice Review, as set out in *Working Together 2023*. They state that "The national reviews we commission may be thematic reviews based on types of cases or systemic issues that we see frequently or are identified as important national issues, or they may be individual case reviews where a particular case is significant in terms of its complexity or implications for national learning."[27]

12.2 The Child Safeguarding Practice Review Panel also states: "An important part of setting up the review process is a dialogue between the Panel and the local areas affected. This helps make sure the scope and methodology of the review maximises the learning potential and the most efficient of resources, including the time of those involved at a local level."[28]

[26] This ensures compliance with Working Together 2023 which requires that "Every effort should also 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.", page 141, paragraph 366.
[27] "Child Safeguarding Practice Review Panel guidance for safeguarding partners" (September 2022), page 33.
[28] "Child Safeguarding Practice Review Panel guidance for safeguarding partners", page 33.

12.3 Where the Safeguarding Children Partnership receives a request around a National Child Safeguarding Practice Review, the Safeguarding Partners and, subsequently, the Case Review Group will be informed about the request and the parameters. The Chair of the Case Review Group will be the main point of contact and the Business Office will help facilitate any information required / local agency attendance at meetings.

This document has been produced for Leicester, Leicestershire and Rutland based on the West Midlands Regional Framework and Practice Guidance for LCSPRs.

It has been adapted with the kind permission of Simon Cross on behalf of the Birmingham Children's Trust.