Child Safeguarding Practice Review Framework

Revised July 2022

Contents

Who this guidance is for

This guidance is for all safeguarding partners, and agencies involved in the Halton Children and Young Peoples Safeguarding Partnership (HCYPSP). It should be read alongside the relevant statutory guidance set out in Working Together to Safeguard Children (2018), Working Together: Transitional Guidance (2018) and Child Safeguarding Practice Review Panel: practice guidance (2019).

Introduction and Context

The Children and Social Work Act 2017 introduced a new legal framework in respect of local safeguarding arrangements for children. Serious Case Reviews were replaced with Child Safeguarding Practice Reviews (CSPR's). The overall purpose of a CSPR is for agencies and individuals to learn lessons, to improve the way which they work, both individually and collectively and to explore how practice can be improved more generally through changes to the system as a whole, in order to safeguard and promote the welfare of 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 (National Panel) and at a local level with the three Safeguarding Partners. In Halton's case this is Cheshire and Merseyside Integrated Care Board, Halton Borough Council and Cheshire Constabulary.

The National Panel does not have the power to require HCYPSP to undertake reviews. The decision to proceed to a Local Child Safeguarding Practice Review (LCSPR) is a local decision for which HCYPSP are accountable. This includes the identification of cases, commissioning and supervising of reviews and the publication of reports and embedding learning.

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. There are other processes for that purpose.

Given the flexibility that local areas are afforded to carry out LCSPR's this guidance does not provide exact instructions on how to undertake a review. It does provide professionals with a guide for the process for LCSPRs and sets out the arrangements through which HCYPSP will determine when to:

- Consider the need for a referral
- Trigger a Rapid Review
- Commence a Local Child Safeguarding Practice Review (LCSPR – formerly known as a Serious Case Review) or
- Undertake another appropriate case review process.

The document also highlights

- HCYPSPs statutory duties
- How HCYPSP will commission such work
- Key document templates

Definition of a Serious Safeguarding Case

Working Together 2018 defines serious child safeguarding cases as those in which abuse of neglect of a child is known or suspected and the child has died or been seriously harmed.

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

Criteria for a Local Child Safeguarding Practice Review (LCSPR)

Safeguarding partners are required, by the Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018, to consider certain criteria and guidance when determining whether to carry out a LCSPR. 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.
- Recurrent themes in the safeguarding and promotion of the welfare of children.
- Concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children.

They must also take into account cases that the National Panel have considered for national review but have then 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 integrated care board is involved, including in cases where families have moved around
- Where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings. This includes children's homes, secure children homes and other settings with residential provision for children. It also includes 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

Meeting the criteria does not mean a LCSPR must automatically be undertaken. The process outlined in this document will be followed to determine whether a review is appropriate (i.e. where there is potential to identify improvements).

LCSPR's 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 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 LCSPR; this will usually be via a Local Reflective Review.

Information Sharing

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

HCYPSP have the authority to request from agencies, information to support both National and Local CSPRs, 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 may be information about parents, guardians and other family members as well as the child / children who are subject of the review.

When making requests for information, HCYPSP will consider their responsibilities under the relevant information law and have regard to guidance provided by the Information Commissioners Office.

How to refer a case for consideration

Any organisation with statutory or official duties in relation to children must inform HCYPSP of any incident which they think should be considered for a review as soon as they become aware of the incident. A Referral form for consideration of a case review is used for this purpose.

To support early identification of relevant cases, consideration of a referral for a Local Child Safeguarding Practice Review should be an agenda item in all multi-agency strategy meetings convened following serious harm to, or death of a child.

The referral form allows a partner to outline the case and propose the process they feel is required either:

1. A Local Child Safeguarding Practice Review or
2. An alternative learning review– potentially leading to a multi or single agency learning process

The completed referral form is submitted to the HCYPSP business unit CYPSafeguardingPartnership@halton.gov.uk) who will notify the Head of Safeguarding and Quality Assurance. It should be noted that when referrals are completed by agencies, that full information requested in the form is required to support decision making. Incomplete forms will be returned to the referrer.

If a Local Child Safeguarding Practice Review (LCSPR) is suggested by the referrer, or information within the referral indicates that this should be considered then the HCYPSP business unit will arrange a **Virtual Panel** (see below) within 1 working day of receipt of the referral.

If the referrer identifies that a LCSPR is not necessary but a Local Reflective Review may be required and referral information will be discussed at the next Executive Group meeting Group and further action agreed there.

The referrer will be informed of the direction of their referral within 5 working days of receipt.

The Virtual Panel

The Virtual Panel consists of the three statutory partners represented by the individuals named below or their designated deputies

- Chief Nurse – Halton PLACE
- Director of Children's Services - Halton Borough Council
- Detective Chief Superintendent – Cheshire Constabulary

The panel will use the criteria defined in Working Together 2018 to consider whether a case/incident meets the threshold for a Notifiable Incident.

16C (1) of the Children Act 2004(as amended by the Children and Social Work Act 2017) states:

Where a Local Authority in England knows or suspects that a child has been abused or neglected, the Local Authority must notify the Child Safeguarding Practice Review Panel if –

(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.

Whilst it is the Local Authority that carries this duty to report, partners are under a duty to inform the safeguarding partners of any incident that they think may meet these criteria.

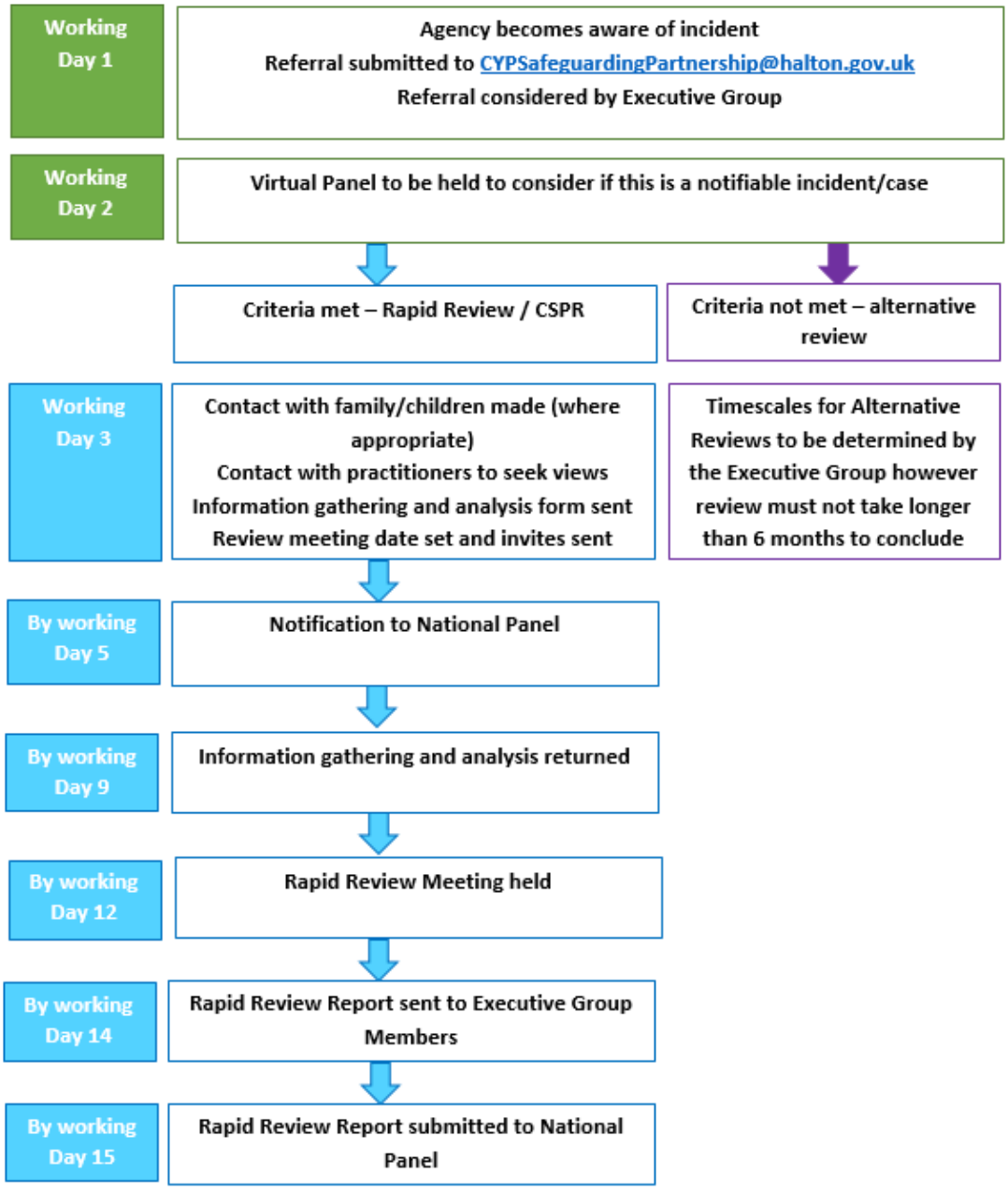
The Virtual Panel will make their decision through virtual communication; email, skype, telephone discussion or a meeting if time permits. The Head of Safeguarding is responsible for ensuring the communication between the panel members is timely and focused.

The Virtual Panel may decide that the incident reported in the referral is not notifiable and may agree that an alternative learning process should be considered; the methodology and scope for this will be discussed and agreed at the next HCYPSP Executive Group Meeting.

Notification of a Serious Safeguarding Incident

If it is agreed that an incident is notifiable there is a duty placed on the Local Authority to notify the National Child Safeguarding Practice Review Panel. This is an online report made via https://www.gov.uk/guidance/report-a-serious-childsafeguarding-incident. The notifiable incident will be reported to the national panel within 5 working days of the referral; the Head of Safeguarding undertakes this action on behalf of the Local Authority.
A Rapid Review meeting must also be held following any notifiable incident; this will be arranged by HCYPSP business unit within 13 working days of the Virtual Panel.

The activity required following the Virtual Panel up to the Rapid Review is detailed in the flow chart below:



Rapid Review Process

The Rapid Review meeting is held for those cases that meet the threshold of a Notifiable Serious Incident or cases where the Virtual Panel has taken a decision that a Rapid Review is the most appropriate way forward. The meeting is convened by HCYPSP business unit within 13 days of incident being identified as reportable and is chaired by a member of the Virtual Panel.

Information gathering and the securing of records

The statutory partners and all agencies who have had involvement with the child or family will be required to contribute to a Rapid Review.

An initial scoping of agencies intervention will need to be completed and relevant information will need to be gathered quickly and this is done through the Rapid Review Report. The purpose of this report is to gather basic facts about the case, including determining the extent of agency involvement with the child and family. More information will be sought if the Rapid Review concludes that a LSCPR or alternative learning review is required. The Excel template for the chronology will also be sent to all relevant agencies once the decision has been made to undertake a Rapid Review (**by working day 3**) along with an accompanying letter that explains the purpose of the report, the requirements of agencies to complete it and associated timescales.

The report should be sent to all agencies thought to be involved with the child and family to check their records and confirm involvement. In addition, partners not directly involved such as housing providers, schools and day care settings should also be included to check their involvement (List in appendix 1).

Invites to the Rapid Review Meeting will be sent to all those agencies who are asked to complete the Rapid Review Report. If agencies are not involved, they will then be uninvited. This process enables those who should be invited to have the date set in their calendar at the earliest point. If additional attendees are required, these will then be added to the invite as they are identified.

Agencies should prioritise the completion of the form and return it within **9 working days** of the referral being received.

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

The Rapid Review Meeting:

The Rapid Review Meeting should aim to:

- Gather the facts about the case as far as they can be readily established at the time.
- Discuss whether there is any immediate action needed to ensure children's safety and share learning appropriately.
- Consider the potential for identifying improvements to safeguard and promote the welfare of children.

  Decide what steps they should take next, including whether or not to undertake a Local Child Safeguarding Practice Review. The criteria that the local safeguarding partners must take into account when deciding whether to initiate a Child Safeguarding Practice Review is detailed on page 4 of this document (Criteria)

The Rapid Review Chair may also wish to invite first line managers and practitioners involved with the case to the first part of the panel if this is considered useful, and it is thought that a discussion with those that know the family would be beneficial to decision making. Those attendees will respectfully be asked to leave during the discussion about threshold and next steps.

If the Rapid Review Panel determine that a Child Safeguarding Practice Review is required, then they will propose the membership of the Scoping Panel/Sub Group to take this review forward.

On completion of the Rapid Review, the Chair of the meeting and Head of Safeguarding will sign off a Rapid Review Chairs Report and share with the National Panel their decision on whether a LCSPR is appropriate.

Within this report there will be reference to:

- Confirmation that the case has been considered against the criteria set out in Working Together (2018).
- Immediate safeguarding arrangements of any children involved.
- A concise summary of the facts, so far as they can be ascertained, about the serious incident and relevant context. This should give sufficient detail to underpin the analysis against the Working Together criteria but does not require lengthy detailed chronologies of agency involvement that can obscure the pertinent facts.
- A clear decision as to whether the criteria for a LCSPR has been met and on what grounds, and if not, why not. Clear reasons are required.
- A recommendation on whether a National CSPR would be considered necessary, and if so, why.
- Any immediate learning already established and plans for their dissemination.
- Potential for additional learning.
- If the decision is taken not to proceed with a LCSPR or Local Reflective Review, a summary of why it is thought there is no further learning to be gained.
- Which agencies have been involved in the Rapid Review, explaining any agency omission whose involvement would be usually expected.

Scrutiny & Challenge

External scrutiny of decision making about the need for a CSPR is offered by the National Panel through the submission of Rapid Review Chair's Reports.

The National Panel may recommend a local panel reconsider their view. They may also choose to take forward utilising a local case as there are national trends emerging that they are best placed to review. In these circumstances the HCYPSP Executive Group should reconvene a meeting to consider the National Panel's decision and reconsider their local decision. If the Executive Group decides not to initiate a LCSPR, they may still support the National Panel's CSPR. This may be through the facilitation of local learning events as directed by National reviewers. This will be coordinated by the HCYPSP business unit.

Local Child Safeguarding Practice Reviews

All LCSPR's in Halton are undertaken by an Independent Reviewer commissioned by HCYPSP and supported by the LCSPR scoping panel and subgroup. Its membership is determined on a case by case basis, dependent on the nature and context of the case. The chair of the group will in most cases be a member of the HCYPSP Executive Group. The Rapid Review is likely to have identified the key lines of enquiry for the LCSPR, and the relevant timescale but the subgroup have delegated authority to finalise the scope of the review and the methodology.

The methodology should provide a way of looking at and analysing frontline practice as well as organisational structures and learning. The methodology should be able to reach recommendations that will improve outcomes for children. All reviews should reflect the child's perspective and the family context.

The review should be proportionate to the circumstances of the case, focus on potential learning, and establish and explain the reasons why the events occurred as they did.

Guidance from the National Panel details that all LSCPR's should be completed no later than six months from the date of the decision to initiate the review.

It is acknowledged that sometimes the complexity of a case does not become apparent until the review is in progress, and parallel processes such as criminal investigations may request that the review delay involving key individuals. If the delay will prevent the publication of the final report within six months, the National Panel should be informed and provided with the reason for the delay.

Involvement of family members, friends, and other support networks

Family members can offer a unique perspective into how the delivery of services and involvement of agencies were viewed and responded to. It is essential that the review sub group have opportunities to listen to family experiences and perspectives and that these contribute meaningfully to the final report.
As a minimum, family members should:

- Be notified of the review process, what that means for them and how they can access support – including impact of media coverage.
- Agree the level and frequency of contact with family members to ensure they are kept informed.
- Be supported to contribute to the review process
- Be included in feedback about the learning identified by the review sub group.
- Be informed and prepared for the publication of the report in a timely manner – again including the likelihood of media interest.
- Be provided with a read only copy of the report which family members can review and comment on prior to publication but not retain, where possible any relevant comments should be incorporated into the final version.

The LCSPR Report

The Lead Reviewer will normally draft the formal report with publication in mind. The format of the final report will be dependent upon the methodology used to undertake the LCSPR.

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

Recommendations within the report should be focused on improving outcomes for children, and they should be clear about what is required of relevant agencies and others collectively and individually and when.

The formal report and recommendations need to be endorsed by the HCYPSP Executive Group.

HCYPSP are required to publish the reports of LCSPR's. In exceptional circumstances the Executive Group may decide to delay or withhold publication, however the justification for any decision not to publish either the full report or information relating to improvements should be set out for the National Panel.

Publication and media planning will be undertaken by the HCYPSP Executive Group once the report has been endorsed. Publication planning will include consideration of the impact of the publication on children, family members, practitioners and others closely affected by the case.

A central point of contact for media enquiries should be identified to ensure effective liaison with each organisations strategic and press leads.

A copy of the full report should be sent to the National Panel no later than seven working days before the date of publication.

Published reports will always include the name of the Lead reviewer and will be made available to read and download from the HCYPSP website. Reports will be publicly available for at least one year.

Disseminating and sharing learning from the review and wider reviews

The HCYPSP Executive Group are 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.
- Where there are single agency recommendations and actions, it is the responsibility of those agencies to ensure that recommendations are fully implemented and used to make improvements to their safeguarding children arrangements.

Monitoring progress

Findings from local learning and improvement activities are reviewed by the Halton Safeguarding Executive Group and used alongside other local information and intelligence to identify emerging trends and issues and develop programmes of action which are managed, monitored and co-ordinated through the Learning and Improvement Tracker (LiT).

Local Reflective Review

If the threshold for a Local or National CSPR is not met or a decision is taken that learning is already embedded so a full CSPR is not necessary, then alternative learning processes or responses can be considered.

A Local Reflective Review will be considered by the HCYPSP Executive Group. They will review the referral and where applicable the record of the Rapid Review meeting to identify if there is multi-agency or single agency learning. If they identify the potential for lessons about how we work together locally then they will identify a lead to take forward a Reflective Review. The form of this review will be determined based on the individual case needs and proportionate for the learning involved. For example, a desk top review may be proposed for

those cases where learning is limited to short periods of time and less complex case elements. In contrast for complex cross border cases then a more complex professional de-brief process may be utilised.

Where the issue relates to a single agency process and system then that agency may be tasked to take forward an appropriate review and report back its findings. This could utilise existing learning processes such as 72 hour reviews or Root Cause Analysis reports.

In each instance, the appropriate learning response will be proposed by the Executive Group and monitored to ensure the learning process is timely and lessons learnt are cascaded across the partnership.

Appendix 1: Organisations to be sent the Rapid Review Form and Chronology

All organisations known to have had involvement with the family should be sent the form and covering email. In order to ensure that all key agencies have checked their involvement however the form should also be sent to the following organisations/ departments:

- Bridgewater NHS (Head of Safeguarding, Named Nurse Safeguarding Children)
- Cheshire Constabulary (Serious Case Review team)
- CRC (Community Director – Cheshire)
- National Probation Service (Senior Operational Support Manager – Cheshire)
- North West Boroughs NHS (Head of Safeguarding, Named Nurse Safeguarding Children)
- Halton Housing (Head of Neighbourhoods)
- The Riverside Group (Neighbourhood Housing Officer)
- Warrington & Halton Hospital (Deputy Chief Nurse, Lead Named Nurse Safeguarding Children)
- Halton Borough Council Adult Social Care (Head of Adult Safeguarding & Quality Assurance)
- Halton Borough Council Children's Social Care (Divisional Manager Children in Need, Divisional Manager Children in Care and Care leavers),
- Halton Borough Council Early Help (Divisional Manager Early Help)
- Halton Borough Council Education Safeguarding Officer (they will identify school/child care contacts who should be contacted separately once identified)
- Youth Justice Service (Head of Service, Youth Offending Service)
- Halton Borough Council Public Health (Commissioning Manager)
- Halton PLACE (they will support Primary Care to complete)
  (Designated Nurse Safeguarding Children and Children in Care, Named Nurse Primary Care)

Appendix 2: Letter/Email to accompany the Information gathering and analysis form

This is a suggested wording to accompany the Rapid Review Report template when sent to agencies. It should be amended to ensure it is appropriate for each case.

Halton Children and Young People's Safeguarding Partnership: Child Safeguarding Practice Review – Information gathering and analysis for a Rapid Review.

HCYPSP have agreed to review the case outlined in the attached Rapid Review Report template and Chronology excel template.

To inform the review agencies need to provide the information within the forms to support understanding of basic facts about the case and determine the extent of agency involvement with the child / children, family members and significant others.

We are asking agencies to:

1. Clarify if your organisation had any involvement with the individuals recorded within the form within the time period: [UPDATE WITH RELEVANT TIME PERIOD FOR THE REVIEW]. If the individuals are not known to your organisation you must confirm this to the Safeguarding Partnership as soon as possible.

2. Secure all records / files in relation to this case, ensuring that they are not accessible to agency personnel other than through yourself or nominated representatives.

3. Complete the attached Information gathering and analysis form if there has been involvement with the individuals.

Completed forms are required to be sent to CYPSafeguardingPartnership@halton.gov.uk by [INSERT SUBMISSION DATE] in order to comply with the national guidance to report on the rapid review within 15 working days.

This form should be completed by the managers of the practitioners working with the individuals involved. Good practice would have the practitioners involved in the process to ensure that the managers have a full understanding of the case when completing the form.

Please note that managers completing this form, and / or practitioners working with the family may be invited to meetings or events to contribute to this review.

If you require any further information, or support in completing the form please contact the Safeguarding Partnerships team at CYPSafeguardingPartnership@halton.gov.uk

Yours sincerely

[Add Learning and Development Officer or HoS whichever is taking the lead]

Encl. Rapid Review Report template

Chronology template