



DARLINGTON

Safeguarding Children Board

Serious Child Safeguarding Review Procedure and Practice Guidance

**(National and Local Child Safeguarding Practice Reviews/Serious
Case Reviews)**



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1. INTRODUCTION AND TRANSITIONAL ARRANGEMENTS

1.1 Transition from Serious Case Reviews (SCRs) to national and local Child Safeguarding Practice Reviews (CSPRs)

For the purpose of this document the term Safeguarding Partners refers to the new statutory arrangements outlined in [Working Together to Safeguard Children 2018](#). The Safeguarding Partners are as follows:

- the Local Authority
- the Clinical Commissioning Group for an area any part of which falls within a local authority area
- the Chief Officer of Police for an area any part of which falls within a local authority area

Throughout the transitional period Darlington Safeguarding Children Board (DSCB) must continue to carry out all statutory functions and continue to make decisions on initiating and publishing SCRs where the criteria are met.

For guidance on the transitional arrangements see the statutory guidance [HM Government: Local Safeguarding Transitional Arrangements](#)

1.2 This guidance has been developed to enable organisations to be clear on their responsibilities, to learn from experience and improve services. This includes the duty to conduct Child Safeguarding Practice Reviews (CSPR)/Serious Case Reviews (SCRs) which are reviews that examine the way agencies and individuals which have been involved with a child/ren have acted when abuse or neglect are suspected or known. The purpose of a CSPR/SCR is to identify learning that will bring about improvements so that the likelihood of harm to children is minimised.

1.3 The Safeguarding Partners/DSCB may also arrange for there to be a review of any other case involving a child/ren in its area with a view to identify lessons to be learned and to apply the learning to future cases. In addition, cases where there is good practice can also be considered.

1.4 This guidance specifies the statutory requirements and the working arrangements in respect of serious child safeguarding incidents, CSPRs/SCRs and alternative learning reviews, including the interface with other reviews such as Domestic Homicide Reviews (DHR), Youth Offending Service (YOS) reviews, Mental Health Homicide Reviews (MHHR) and Multi-agency Public Protection Arrangements (MAPPA) reviews.

1.5 For the purpose of this document reference is made to the following Panels:

- **The Child Safeguarding Practice Review Panel (The Panel)** - this is the national panel appointed by the Secretary of State for Education which considers all notifications of serious incidents. The Local Authority is required to inform the Child Safeguarding Practice Review Panel within five days of the receipt of a notification.
- **The Rapid Review Panel**- this is the local panel which meets within fifteen days of a notification to the Child Safeguarding Practice Review Panel to consider the circumstances of a notifiable incident. The Rapid Review Panel is

chaired by the Safeguarding Partners/DSCB and will determine if it is considered that the criteria for a CSPR (or SCR during the transitional period) have or have not been met. If it is agreed that the CSPR (or SCR during the transitional period) criteria are met, the Rapid Review Panel will make a recommendation to the Child Safeguarding Practice Review Panel on the level of review.

2. THE CHILD SAFEGUARDING PRACTICE REVIEW PANEL

2.1 The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018 provides the framework for the review of serious child safeguarding cases and the role and remit of the Child Safeguarding Practice Review Panel. The Child Safeguarding Practice Review Panel considers all notifications of serious incidents. Section 16 B Children Act 2004 (as amended by the Children and Social Work Act 2017) outlines the functions of the Child Safeguarding Practice Review Panel as:

- I. to identify serious child safeguarding cases in England which raise concerns which raise issues that are complex or of national importance and
- II. where it is considered appropriate to arrange for those cases to be reviewed under the supervision of the Panel.

The Child Safeguarding Practice Review Panel is responsible for identifying and overseeing the review of serious child safeguarding cases which raise complex issues or which are of national importance. The Panel will also maintain oversight of the system of national and local reviews and judge how effectively a review is operating.

3. DEFINITION OF A SERIOUS CHILD SAFEGUARDING INCIDENT AND 'SERIOUS HARM'

3.1 [Working Together to Safeguard Children 2018](#) (Chapter 4, paragraph 12) defines a serious child safeguarding incident as circumstances where it is known or suspected that a child has been abused or neglected which meet the following criteria:

- 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.

3.2 'Serious harm' is defined by S 16 B (9) Children Act 2004 (as amended by the Children and Social Work Act 2017) as a potentially life threatening injury and includes serious or long term impairment of mental health or intellectual, emotional, social or behavioural development.

'Serious harm' is defined in Working Together to Safeguard Children 2018 as including (but not limited to) serious and/or long term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It also covers impairment of physical health. This is not an exhaustive list and 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. RESPONSIBILITIES OF ALL ORGANISATIONS TO NOTIFY THE LOCAL AUTHORITY WHEN A SERIOUS CHILD SAFEGUARDING INCIDENT OCCURS

- 4.1 When a serious child safeguarding incident occurs the first step for any organisation is to take appropriate action to ensure the immediate safety of the child/ren or minimise the impact of any serious harm (refer to the [Child Protection Procedures](#) for further guidance).
- 4.2 In all circumstances staff should consult with the Safeguarding Lead/Senior Manager within its own organisation and follow internal processes to ensure that:
- where a child has died or suffered serious harm, the organisation will make a referral to the Local Authority
 - the organisation must complete the Notifiable Incident Form [insert link] and forward to DSCB/Safeguarding Partnership Business Unit LSCB@darlington.gov.uk which will then **immediately** forward the notification to the Director of Children and Adult Services.

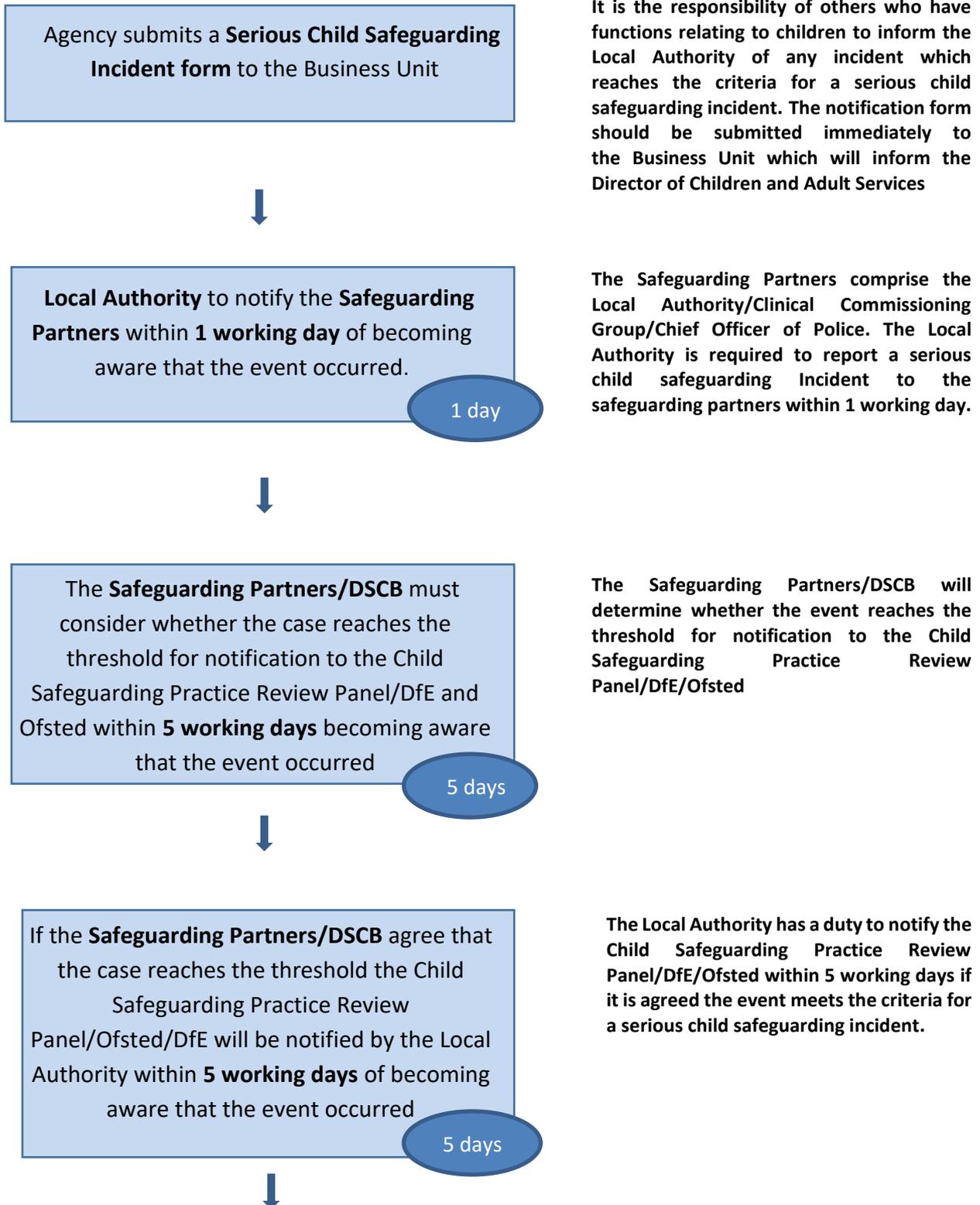
It is the responsibility of others who have functions relating to children to inform Local Authority of any incident which they think reaches the criteria for a serious child safeguarding incident notification (as outlined in paragraph 2). The Local Authority is required to inform the Safeguarding Partners/DSCB of the serious child safeguarding incident and it will be determined whether the case reaches the threshold for a referral to the Child Safeguarding Practice Review Panel and whether a local or national Child Safeguarding Practice Review is required.

For further guidance see Serious Child Safeguarding Incident Procedure and Practice Guidance [insert link]

- 4.3 Where a child has died unexpectedly, the organisation should also follow the [Child Death Review Procedures](#).

5 FLOWCHART OUTLINING THE PROCESS AND THE TIMESCALES

5.1 The following process map summarises the process and timescales for the Safeguarding Partners when considering whether a Serious Child Safeguarding Incident reaches the threshold for a Child Safeguarding Practice Review and the procedure which must be followed:



The Local Authority should also inform the referrer of the outcome of the notification within **5 working days** of the receipt of the notification

5 days

It is expected that the Local Authority will inform the referrer of the outcome of the notification.



The **Safeguarding Partners/DSCB** convenes a **Rapid Review Panel** within **7-10 working days** of acknowledgement from the Child Safeguarding Practice Review Panel.

7-10 days

Once the Safeguarding Partners/DSCB determine that the criteria are met a Rapid Review Panel will be convened. This should be held within 7-10 working days to enable agencies to collate relevant information and to allow time to make recommendation to the lead Safeguarding Partners/DSCB who will make the final decision as to the level of the review. The Rapid Review Panel will be chaired by representatives of the Safeguarding Partners.



The **Safeguarding Partners/DSCB** will inform the **Child Safeguarding Practice Review Panel** of the decision of the level of review within **15 working days** of the acknowledgement of the receipt of the notification

15 days

The Child Safeguarding Practice Review Panel is informed of the decision of level of review to be undertaken within the required timescales (15 working days) and the rationale for the decision.



The **Child Safeguarding Practice Review Panel** will consider the recommendation and review the case at the next Panel meeting to decide whether the case reaches the criteria for a national or local review and will advise the Safeguarding Partners/DSCB in writing of the decision

The Child Safeguarding Practice Review Panel will notify the Safeguarding Partners/DSCB of the decision as to whether the Panel intends to undertake a national review and will provide the rationale for the decision.

6. RESPONSIBILITY OF THE LOCAL AUTHORITY TO NOTIFY THE SAFEGUARDING PARTNERS/DSCB

- 6.1 The Local Authority is required to report a serious child safeguarding incident to the Safeguarding Partners /DSCB **within one working day** of becoming aware that the event has occurred. The Safeguarding Partners/DSCB will determine whether the event reaches the criteria for a notification to Ofsted, Child Safeguarding Practice Review Panel and the Secretary of State for Education (DfE).
- 6.2 If the Safeguarding Partners/DSCB agree that the criteria have been reached for a serious child safeguarding incident notification (see paragraph 3) the Local Authority will notify the Child Safeguarding Practice Review Panel.
- 6.3 It is expected that the Local Authority will feedback to the referrer the outcome of the notification within five working days of the decision being made. If the referrer is dissatisfied with this outcome the matter should be discussed with the Director of Children and Adult Services and or with the Safeguarding Partners/DSCB, additional guidance is available in the [Professional Challenge Procedure and Guidance](#).

7. DUTY OF THE LOCAL AUTHORITY TO NOTIFY SERIOUS CHILD SAFEGUARDING INCIDENTS TO THE CHILD SAFEGUARDING PRACTICE REVIEW PANEL

- 7.1 The Local Authority has a statutory duty under [Working Together to Safeguard Children 2018](#) (Chapter 4, paragraph 12) to refer all serious child safeguarding incidents to the Child Safeguarding Practice Review Panel. A serious child safeguarding incident refers to circumstances where it is known or suspected that a child has been abused or neglected which meet the following criteria:
- c) the child dies or is seriously harmed in the local authority's area, or
 - d) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.
- 7.2 If the Safeguarding Partners/DSCB determine that a case meets the criteria for a serious child safeguarding incident the Local Authority must notify the Child Safeguarding Practice Review Panel **within five working days** of becoming aware that the event has occurred.
- 7.3 Online notifications to the Child Safeguarding Practice Review Panel will also be shared with Ofsted (to inform its inspection and regulatory activity) and with DfE to enable it to carry out its functions.
- 7.4 The Local Authority must also notify the Secretary of State for Education (DfE) and Ofsted where a child looked after has died, whether or not abuse or neglect is known or suspected.
- 7.5 If the Safeguarding Partners/DSCB determine that a case meets the criteria for a serious child safeguarding incident a Rapid Review Panel should be convened.

8. THE RAPID REVIEW PANEL

- 8.1 Once the Safeguarding Partners/DSCB have determined that a case meets the criteria for a serious child safeguarding incident a Rapid Review Panel meeting should be convened. The purpose of the Rapid Review Panel meeting is to decide whether the serious child safeguarding incident reaches the threshold for a national or local Child Safeguarding Practice Review (CSPR/LSCPR)/SCR (during the transitional period).
- 8.2 The Rapid Review Panel meeting will take place within **7-10 working days** of the acknowledgement of the receipt of the notification to consider the information in line with any guidance issued by the Child Safeguarding Practice Review Panel. This is to allow sufficient time to report to the Child Safeguarding Practice Review Panel within the required timescales (15 working days from receipt of the acknowledgement of the notification).
- 8.3 The Rapid Review Panel meeting will be chaired by a representative(s) of the Safeguarding Partners and will be attended by members of the Safeguarding Partnership/DSCB/Case Review and Learning from Practice sub-group (during the transitional period), supplemented by additional practitioners with the necessary knowledge or expertise pertinent to the circumstances of the case. The Rapid Review Panel may also wish to have available specialist advisers whose role will be to advise panel members during the process.
- 8.4 The Rapid Review Panel meeting will have the expertise required to make the recommendation to the Safeguarding Partners/DSCB. The Rapid Review Panel will be provided with information/reports from the key agencies involved which will inform the decision making as to whether the criteria are met. This information includes the nature of agency involvement with the child(ren)/family, any safeguarding issues of which the agency was aware during the involvement and what information the agency holds in respect of the incident. For the purposes of the Rapid Review Panel the Safeguarding Partners/DSCB will request information dating back no more than 3 years. However, if agencies are of the opinion that there is relevant information outside of this timescale, this information should be shared at the meeting. It is important for the panel to have sufficient information before discussion begins. However, the Rapid Review Panel is not investigating the circumstances of the incident and is not conducting the CSPR/SCR, so the consideration of issues should be proportionate.
- 8.5 The aim of the rapid review is to enable the Safeguarding Partners/DSCB to:
- gather facts about the case
 - discuss whether any immediate action is needed to ensure the safety of children
 - decide what steps they should take next, including whether or not to undertake a Local Child Safeguarding Practice Review (LSCPR)/SCR.
- 8.6 After reviewing all the information available against the criteria and guidance, the Rapid Review Panel will determine if it is considered whether the criteria for a LCSPR/SCR have or have not been met.
- 8.7 If it is agreed that the LCSPR/SCR criteria are met, the Rapid Review Panel Chair will provide a recommendation to the lead Safeguarding Partners as to whether a national

or local review is appropriate. The Rapid Review Panel Chair may also make recommendations on the review methodology and whether an independent chair and/or author are required.

- 8.8 If the Rapid Review Panel considers a LCSPR/SCR should not be held, it may recommend that another form of review or investigation is appropriate. This could include a single agency review or a smaller scale audit of agency involvement. This might be the case where for instance there is a safeguarding element and lessons to be learned regarding the conduct of an agency but where there is no or little concern regarding involvement from other agencies; or where it is considered that a broader scale review would be disproportionate to the concerns or to the learning.
- 8.9 Upon conclusion of the Rapid Review Panel the outcome will be reported to the lead of the Safeguarding Partners/DSCB Independent Chair (during the transitional period) who will make the final decision on the level of review. The Child Safeguarding Practice Review Panel will be informed of the decision about whether a LCSPR/SCR is appropriate or whether it is the view of the Rapid Review Panel that the case may raise issues which are complex or of national importance such that a national review may be appropriate. The decision of the Safeguarding Partners and Independent Chair will be reported to the Child Safeguarding Review Panel within **15 working days** of the acknowledgement of the receipt of the notification.
- 8.10 On receipt of the information from the Safeguarding partners/Independent Chair the Child Safeguarding Practice Review Panel will decide whether it is appropriate to commission a national review of the case.
- 8.11 The Child Safeguarding Practice Review Panel will notify the Safeguarding Partners/DSCB Independent Chair (during the transitional period) of the decision on whether the Panel intends to undertake a national review and will provide the rationale for the decision. The Child Safeguarding Practice Review Panel will also inform the Secretary of State when a decision is made to carry out a national Child Safeguarding Practice Review.

9. THE DECISION OF THE CHILD SAFEGUARDING PRACTICE REVIEW PANEL

- 9.1 On receipt of the information from the Rapid Review Panel, the Child Safeguarding Practice Review Panel must decide whether it is appropriate to commission a national review of the case and must consider whether the case:
- highlights improvements needed to safeguard and promote the welfare of children including those where improvements have been previously identified
 - raises or may raise issues regarding legislative change or changes to guidance issued under or further to any enactment
 - highlights recurrent themes in the safeguarding and promotion of the welfare of children.
- 9.2 The Child Safeguarding Practice Review Panel will also have regard to the following circumstances:
- significant harm to or death of a child educated otherwise than at school

- where a child is seriously harmed or dies whilst in the care of the local authority or whilst on (or recently removed from) a child protection plan
- cases which involve a range of types of abuse, for example trafficking for the purpose of child sexual exploitation
- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings which includes children's homes and settings with residential provision for children, including secure settings. It also includes police custody, young offender institutions and all settings where the detention of a child takes place including under the Mental Health Act 1983 or the Mental Capacity Act 2005.

9.3 As well as considering notifications from the local authority and information from the Rapid Review Panel the Child Safeguarding Practice Review Panel can take into account a range of other evidence including inspection reports and research. The Child Safeguarding Practice Review Panel may take into account any other criteria considered appropriate to identify whether a LCSPR raises issues which are complex or of national importance.

In many cases there will need to be dialogue between the Safeguarding Partners/DSCB and the Child Safeguarding Practice Review Panel to support the decision making process. The Safeguarding Partners/DSCB must share further information with the Child safeguarding Practice Review Panel as requested.

9.4 The Child Safeguarding Practice Review Panel should inform the Safeguarding Partners/DSCB promptly following the receipt of the review if it is considered that:

- a national review is appropriate, setting out the rationale for the decision and the next steps
- further information is required to support the Child Safeguarding Practice Review Panel's decision making (including whether the safeguarding Partners/DSCB have taken a decision as to whether to commission a local review/SCR).

9.5 The Child Safeguarding Practice Review Panel should take decisions on whether to undertake national reviews and communicate the rationale appropriately including communication with families. The Child Safeguarding Practice Review Panel should notify the Secretary of State when a decision is made to carry out a national review.

9.6 If the Child Safeguarding Practice Review Panel decides to undertake a national review the Panel should discuss with the Safeguarding Partners/DSCB the potential scope and methodology of the review and how the Panel will engage with the safeguarding Partners/DSCB and those involved in the case.

9.7 There will be instances where a local review has been carried out which could then form part of a thematic review that the Child Safeguarding Practice Review Panel undertakes at a later date. There may also be instances when a local review has not been carried out where the Child Safeguarding Practice Review Panel considers that the case could be helpful to a national review at some stage in the future. In such circumstances Child Safeguarding Practice Review Panel should engage with the Safeguarding Partners/DSCB to agree the conduct of the review.

- 9.8 Alongside any national or local reviews there could be a criminal investigation or a coroner's enquiry and/or other professional body disciplinary procedures. The Child Safeguarding Practice Review Panel and Safeguarding Partners/DSCB should have clear processes about how they will work with other investigations, including Domestic Homicide Reviews, Mental Health Homicide Reviews, MAPPA reviews and Safeguarding Adult Reviews and work collaboratively with those carrying out the reviews. This is essential to reduce the impact on children and families and to minimise the duplication of effort.

10. LOCAL CHILD SAFEGUARDING PRACTICE REVIEWS - GUIDANCE

- 10.1 The Safeguarding Partners/DSCB must make arrangements to:
- identify serious child safeguarding cases which raise issues of importance in relation to the area and
 - commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken
- 10.2 When a serious child safeguarding incident becomes known to the Safeguarding Partners/DSCB, they must consider whether the case meets the criteria for a Child Safeguarding Practice Review and whether the review is a local or national review (in line with transitional arrangements).
- 10.3 Meeting the criteria does not mean that the Safeguarding Partners /DSCB must automatically carry out a local Child Safeguarding Practice Review. It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice. Issues might appear to be the same in some child safeguarding cases but reasons for actions and behaviours may be different and so there may be different learning to be gained from similar cases.
- 10.4 Conversely, some cases may not meet the definition of a 'serious child safeguarding case', but nevertheless raise issues of importance to the local area. This may include cases where there has been good practice, poor practice or where there have been 'near miss' events. Safeguarding Partners/DSCB may choose to undertake a local Child Safeguarding Practice Review in these or other circumstances.
- 10.5 Decisions on whether to undertake reviews should be transparent and the rationale communicated appropriately, including to families. If following consideration it is identified that it is not appropriate to conduct a review and the incident does not relate to the unexpected death of a child, Safeguarding Partners/DSCB will close the referral as no further action.
- 10.6 The Safeguarding Partners/DSCB must also take into account whether the case:
- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including cases where those improvements have previously been highlighted
 - highlights or may highlight recurrent themes in the safeguarding and the 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 in which the Child Safeguarding Practice Review Panel has considered and concluded a local review may be more appropriate.

10.7 The Safeguarding Partners/DSCB should also have regard to the following circumstances:

- where the Safeguarding Partners/DSCB have cause for concern about the actions of a single agency
- where there has been no agency involvement and this give Safeguarding Partners/DSCB a cause for concern
- where more than one local authority, police area or Clinical Commissioning Group is involved, including cases where families have moved round.
- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings. This includes children's homes (including secure establishments) and other settings for residential provision for children such as custodial settings including police custody, young offender institutions and secure training centres and all settings where the detention of a child takes place, including under the Mental Health Act 1983 or the Mental Capacity Act 2005.

10.8 The Safeguarding Partners/DSCB must co-operate in and contribute to the carrying out of a review under this section with a view to:

- identifying the lessons to be learned from the child/ren's case and
- applying those lessons to future cases

11. PURPOSE AND PRINCIPLES OF A CHILD SAFEGUARDING PRACTICE REVIEW

11.1 The purpose of a Child Safeguarding Practice Review (CSPR) is to promote effective learning and improvement action, through identifying what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. It is not an investigation.

11.2 The purpose of a CSPR is not to hold any individual or organisation to account as other processes exist for that. These include criminal proceedings, disciplinary procedures, employment law and those of relevant service and professional regulatory bodies.

11.3 A CSPR should highlight any lessons that can be learned from the case and through a clear set of recommendations; ensure that relevant actions are taken in order to help prevent future deaths or serious harm. This helps to improve both single and inter agency working and better safeguard and promote the welfare of children.

11.4 The Safeguarding Partners/DSCB should be primarily concerned with determining what type of review process best enables this to happen. The level of the review will be

determined by the Safeguarding Partners/DSCB following a recommendation from the Rapid Review Panel.

12. COMMISSIONING A LOCAL CHILD SAFEGUARDING PRACTICE REVIEW

- 12.1 The Safeguarding Partners/DSCB are responsible for commissioning and supervising reviewers for a Local Child Safeguarding Practice Review (LCSPR). All LCSPRs should be conducted in accordance with [NSPCC Quality Markers](#) which are designed to support commissioners and lead reviewers to commission and conduct high quality reviews by providing a consistent and robust approach to the process. In all cases it should be considered whether the reviewer has the following:
- professional knowledge, understanding and practice relevant to local child safeguarding practice reviews including the ability to engage both with practitioners and children and families
 - knowledge and understanding of research relevant to children's safeguarding issues
 - ability to recognise the complex circumstances in which practitioners work together to safeguard children
 - ability to communicate findings effectively
 - whether the reviewer has any real or perceived conflict of interest
- 12.2 The Safeguarding Partners/DSCB will agree with the reviewer the method by which the review should be conducted in accordance with the guidance and principles outlined in the [Munro Review](#). 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 which will improve outcomes for children. All reviews should reflect the child's perspective and family context.
- 12.3 The review should be proportionate to the circumstances of the case, focus on potential learning and establish and explain why events happened as they did.
- 12.4 As part of the duty to ensure that the review is of satisfactory quality, the Safeguarding Partners/DSCB should seek to ensure that:
- practitioners are fully involved in reviews and invited to contribute their perspective without fear of being blamed for actions they took in good faith
 - families, including surviving children, are invited to contribute to reviews. This is important for ensuring that the child is at the centre of the process¹. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- 12.5 The Safeguarding Partners/DSCB must supervise the review to ensure that the reviewer is making satisfactory progress and that the review is of satisfactory quality. The Safeguarding Partners/DSCB may request information from the reviewer during the review to enable them to assess progress and quality; such requests should be
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made in writing. [The President of the Family Division's Guidance](#) should also be noted in the context of Child Safeguarding Practice Reviews.

- 12.6 The Safeguarding Partners/DSCB will give consideration to the most appropriate methodology to use as no one model will be appropriate for all cases. The most appropriate methodology will normally be that which provides the best opportunity to learn; however it will be determined by and proportionate to the specific circumstances and the scale of the situation. (See Appendix 1 for additional information on review tools and methodologies).

13. LOCAL CHILD SAFEGUARDING PRACTICE REVIEW-GOVERNANCE GROUP

- 13.1 In all LCSPRs a Governance Group will meet to agree the scope of the review and determine the Terms of Reference. The Governance Group will be chaired by the same Chair of the Rapid Review Panel.
- 13.2 The Governance Group and the other arrangements should be proportionate to the circumstances of the case and the review methodology.
- 13.3 The Governance Group will set a meeting schedule and timings and will need to meet a minimum of 3 times in order to establish, monitor and finalise the review.
- 13.4 The Safeguarding Partners/DSCB will exercise the function of having oversight of the actions via the Case Review and Learning from Practice sub-group. The sub-group will ensure that identified actions are completed, and any barriers or slippage in achieving outcomes are responded to. All improvement actions will be recorded in an action plan which will be regularly reviewed and monitored by the sub-group which will ensure that learning outcomes are embedded in the respective organisations. The actions will be monitored within an action log and exception report which will be monitored by the sub-group. The Chair of the sub-group will seek an explanation from relevant agencies in respect of outstanding actions and in accordance with the escalation process will inform the relevant Head of Service in cases where actions are not completed three months beyond the specified deadline. The Chair of the sub-group will request confirmation of what action will be taken to rectify the matter. In cases where actions remain outstanding at six months beyond the original deadline the Chair of the sub-group will inform the Chief Officer of the agency concerned and will seek information about what steps are being taken to complete the action. An extension to the original deadline should only be agreed in exceptional circumstances and at the request of the Chief Officer. In exceptional circumstances there may be a requirement for the Chair of the sub-group to involve the Safeguarding Partners/Independent Chair DSCB in the escalation process.
- 13.5 Every effort should also be made both before the review and whilst it is in progress to capture points from the case about improvements needed and to take corrective action and disseminate learning.

14. INTERFACE WITH OTHER REVIEWS AND INVESTIGATIONS

- 14.1 There are a number of types of review and investigations that may interface with a Local Child Safeguarding Practice Review (LCSPR) and it is important to identify any other processes which may be running in parallel or being considered. These include a

Safeguarding Adult Review (SAR), Domestic Homicide Review (DHR), Mental Health Homicide Reviews (MHHR), safeguarding and serious incident investigations, disciplinary processes, judicial reviews, complaints, criminal justice processes, YOS reviews, Coroner inquests and S 47 Child protection investigations and criminal investigations. For further details of other types of review/investigation see Appendix 2.

- 14.2 In setting up a LCSPR, the Safeguarding Partners/DSCB must consider how the LCSPR will interface with other processes or investigations. Important principles in planning include ensuring adherence to any separate statutory requirements, ensuring appropriate expertise and knowledge, reduction of duplication, maximising effectiveness and learning and minimising the impact on those affected by the case.
- 14.3 Where there are possible grounds for both a LCSPR and a Safeguarding Adult Review (SAR) or a Domestic Homicide Review (DHR) or a Mental Health Homicide Review (MHHR) a decision should be made at the outset by the respective decision making bodies as to how they will coordinate the reviews, engagement and report(s). This may result in some parts being jointly commissioned and overseen, or one Board leading, with the same or different reports being taken to each commissioning body.
- 14.4 Any LCSPR will need to take account of a Coroner's enquiry and/or any criminal investigation including disclosure issues, which may impact on timescales. It will be the LCSPR lead's role to ensure the necessary contacts are maintained with appropriate people.

15. ENGAGEMENT WITH FAMILIES

- 15.1 A core principle of safeguarding is to work with families in an open and honest way and this needs to be replicated in the Local Child Safeguarding Practice Review (LSCPR). Being clear about the purpose and function of the LCSPR helps manage the expectations of family members about what the LCSPR can achieve. Within this context family are usually close relatives, including those with parental responsibility. There is an increasing body of evidence that family members, including surviving children, can make a valuable contribution to professional understanding and should be invited to contribute to the review process. Consideration will be given to the earliest point in the process that the family will be involved. In all circumstances when information is to be shared between organisations, consent issues must be discussed and obtained for family members. Where it is deemed not appropriate to seek consent, the rationale for the decisions should be clearly recorded. A decision should be made at an early stage in the LCSPR process about who is best placed to engage with the family.

16. CONSIDERATIONS FOR DISCLOSURE/INFORMATION SHARING IN A LSCPR

- 16.1 The Safeguarding Partners/DSCB are not a public authority for the purposes of the Freedom of Information Act 2000.
- 16.2 [Section 14B of the Children Act 2004](#) (as amended by the Children and Social Work Act 2017) sets out expectations in relation to information sharing between agencies and Safeguarding Partners/DSCB in relation to LCSPRs including an expectation that

information must be shared to enable the Safeguarding Partners/DSCB to fulfil their function.

- 16.3 Information must be shared in accordance with principles outlined in the [Data Protection Act 2018](#) and [General Data Protection Regulations](#) and the [Darlington Protocol for Collaborative Working and Information Sharing between Professionals to Protect Children and Vulnerable Adults](#).
- 16.4 Information sharing between Safeguarding Partners/DSCB and H.M. Coroner is not defined in statute however case law in relation to information sharing has set a precedent. Once the Coroner has been informed that the Safeguarding Partners/DSCB have commissioned a LCSPR information sharing in relation to LCSPR documents should be considered on a case by case basis. On receipt of a request for documents relating to a LCSPR from the Coroner, The Safeguarding Partners/DSCB will seek legal advice in order to consider Public Interest Immunity arguments.

17. EXPECTATIONS FOR THE FINAL REPORT

- 17.1 The final LCSPR report should be completed in accordance with [NSPCC quality markers](#) (quality marker 14) and should clearly identify the analysis of the findings of the LCSPR that are key to making improvements whilst keeping details of the family to a minimum. There is often information about the case already in the public arena, for example media publications and anonymised family court reports and much of this information is readily available on the internet. Therefore, personal and sensitive information about family members should not be included and precise details of the case should be minimised.
- 17.2 The main function of the report is to make accessible the analysis to support the necessary improvement work and the report should include the following:
- a summary of any recommended improvements to be made by persons in the area to safeguard and promote the welfare of children
 - provide an analysis of any systemic and underlying reasons why actions were taken or were not in respect of matters covered by the report
- 17.3 Recommendations should be clear on what is required of relevant agencies collectively and individually within specified timescales and focussed on improving outcomes for children.
- 17.4 Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond and the Safeguarding Partners/DSCB should publish the report unless it is considered inappropriate to do so. The name of the reviewer should be published and published reports or information about the improvement required must be publicly available for at least one year. In circumstances where it is deemed that publication is inappropriate, consideration should be given to the publication of information about any improvements which are required.
- 17.5 When compiling and preparing to publish the report the Safeguarding Partners/DSCB should consider how to carefully manage the impact of the publication on children, family members, practitioners and others affected by the case. The Safeguarding

Partners/DSCB should ensure that reports are written in such a way that publication does not harm the welfare of children and vulnerable adults involved in the case.

- 17.6 The Safeguarding Partners/DSCB must send a copy of the full report to the Child Safeguarding Practice Review Panel and the Secretary of State no later than **seven working days** before the date of publication. In cases where there is a decision to publish only the learning and recommendations a copy of this must also be provided Child Safeguarding Practice Review Panel and the Secretary of State within the same timescales. The Safeguarding Partners/DSCB should also provide the report (or information about improvements) to Ofsted within the same timescale.

18. PUBLICATION OF THE REPORT

- 18.1 Depending on the nature and complexity of the case the report should be completed and published as soon as possible and no later than **six months** from the date of the decision to initiate a review. Where other proceedings may have had an impact on or delayed publication (for example an ongoing criminal investigation, inquest or pending prosecution) the Safeguarding Partners/DSCB should inform the Child Safeguarding Practice Review Panel and the Secretary of State of the reason for the delay. The Safeguarding Partners/DSCB should also set out to the Child Safeguarding Practice Review Panel and the Secretary of State any decision not to publish either the full report or information relating to improvements. The Safeguarding Partners/DSCB should have regard to any comments that the Child Safeguarding Practice Review Panel or the Secretary of State may make in respect of publication.
- 18.2 Every effort should also be made, both before the review and whilst it is in progress to (i) capture points from the case about improvements and (ii) take corrective action and disseminate learning.

19. MEDIA/COMMUNICATION AND PUBLICATION OF THE REPORT

- 19.1 The media strategy will be considered by the Rapid Review Panel/ Governance Group at the beginning of the process after the review has been commissioned and will be approved by the Safeguarding Partners/DSCB. Media and communication issues will be coordinated by Darlington Borough Council Communications team in collaboration with the Communications teams of other agencies involved to ensure consistency.
- 19.2 In the interests of transparency the Safeguarding Partners/DSCB should consider publishing the LCSPR report within legal parameters. The Safeguarding Partners/DSCB will make the final decision on whether the LCSPR report will be published in full or whether to publish only the learning outcomes. Advice will be sought from the DBC Communications and Media team in respect of publication and media releases.
- 19.3 The Safeguarding Partners/DSCB should also set out for the Panel and the Secretary of State the justification for any decision not to publish either the full report or information relating to improvements. Safeguarding Partners/DSCB should have regard to any comments that the Panel or the Secretary of State may make in respect of publication.

- 19.4 If appropriate, at the point of publication the Safeguarding Partners/DSCB Independent Chair will release a press statement via the Communications Team outlining the reason for the review, the key findings and the required actions. The Safeguarding Partners/DSCB will retain discretion over the process and timing of publication taking into account such factors as ongoing criminal investigations or court proceedings.

20. CONCLUSION AND DEBRIEF OF THE REVIEW

- 20.1 Once the review process has been completed the Independent Reviewer will present the report to the Safeguarding Partnership/DSCB and the findings will be discussed in detail. The Safeguarding Partnership/DSCB will review the learning outcomes and suggested recommendations for improvement. Improvement actions must be clearly communicated and achievable in the timescales considered.
- 20.2 Improvement actions will be recorded in an action plan which will be regularly reviewed and monitored by the Case Review and Learning from Practice sub-group which will ensure that learning outcomes are embedded in the respective organisations. The actions will be monitored within an action log and exception report which will be monitored by the sub-group. The Chair of the sub-group will seek an explanation from relevant agencies in respect of outstanding actions and in accordance with the escalation process will inform the relevant Head of Service in cases where actions are not completed three months beyond the specified deadline. The Chair of the sub-group will request confirmation of what action will be taken to rectify the matter. In cases where actions remain outstanding at six months beyond the original deadline the Chair of the sub-group will inform the Chief Officer of the agency concerned and will seek information about what steps are being taken to complete the action. An extension to the original deadline should only be agreed in exceptional circumstances and at the request of the Chief Officer.
- 20.3 Where multi-agency learning is identified this will be shared with the Training sub-group and the Policy Development and Practice sub-group and incorporated into multi-agency training and policy and practice guidance (pending the implementation of the new safeguarding arrangements).

21. ACTIONS IN RESPONSE TO LOCAL AND NATIONAL REVIEWS

- 21.1 The Safeguarding Partners/DSCB should take account of the findings from their own local reviews and from all national reviews, with a view to considering how identified improvements should be implemented and embedded locally, including the way in which organisations and agencies work together to safeguard and promote the welfare of children. The Safeguarding Partners/DSCB should highlight findings from reviews with relevant parties locally and should regularly audit progress on the implementation of recommended improvements. Improvement should be sustained through regular monitoring and follow up of actions by the CR&LP and subsequent auditing so that the findings from these reviews make a real impact on improving outcomes for children.

22. ANNUAL REPORT

- 22.1 The findings from Child Safeguarding Practice Reviews will be included in the Annual Report along with relevant service improvements and actions and the reasons for any decisions not to implement actions.

Child Safeguarding Practice Review Methodologies

Traditional model

This methodology, a traditional model, forms the basis of DHR and CSPR in similar fields and historically in children's safeguarding. Typical features include:

- appointment of a panel, including chair (usually independent) and core membership- which determines terms of reference and oversees process
- independent report author
- combined chronology of events (see below)
- involved agencies produce Individual Management Reports(see below), outlining involvement and key issues
- overview report with analysis, lessons learned and recommendations
- relevant agencies produce action plans in response to the lessons learned
- formal reporting to the commissioning board and monitoring implementation across partnerships

Individual Management Reviews (IMR)

IMR's are a means of enabling organisations to reflect and critically analyse their involvement, to identify good practice and areas where systems, processes, or individual and organisational practice could be enhanced. They are key learning tools used in several of the CSPR methodologies and other similar reviews such as DHRs and SARs. They can be used in a multi or single agency environment.

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

Where it is decided that IMRs are required:

- the Chair of the Governance Group should write to the Chief Officer of the organisations involved, providing the template for an IMR
- organisational reports should be prepared by a senior officer and should provide a critical analysis of the organisation's management of the case and identify the lessons learned and actions taken or to be taken
- in the case of NHS organisations already completing a Serious Incident investigation the information produced such as a report, chronology, findings and an action plan should be transferred to the IMR document, within the scope of the terms of reference agreed
- IMRs must be signed off by the Chief Officer of each organisation

Multi Agency Chronology

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

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

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

The chronologies are then combined in a desk top exercise. This enables review by an individual, for example in determining whether there appears to be grounds for further investigation or potential for learning; or where this is the case, more detailed examination and discussion in a multi-agency workshop. This latter process will usually benefit from a facilitator.

Any identified learning points should be noted and translated into actions which are shared with the Safeguarding Partners and implemented.

Advantages and disadvantages of traditional review approach

The relative merits and drawbacks of a traditional methodology are outlined below.

Advantages:

- more familiar to the Safeguarding Partners /stakeholders, who may consider it more robust/objective
- where public/political confidence may only be assuaged via a tried and tested approach
- where there is multiple abuse or high profile cases/serious incident
- methodology is likely to be compatible with an Adult SARs/DHR.

Disadvantages:

- can be overly bureaucratic
- experience of protracted-implementation of lessons learned/recommendations and may not be sufficiently responsive to time considerations
- costly-costs may not justify the outcomes
- more likely to be perceived as attributing blame
- frontline staff often precluded, so disengagement from process and subsequent learning

Action learning approach:

This option is characterised by reflective/action learning approaches, which identify both areas of good practice and those for improvement and do not apportion blame. This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments.

The broad methodology is:

- scoping of review/terms of reference: identification of key agencies/personnel, roles; timeframes:(completion, span of person's history); specific areas of focus/exploration
- appointment of facilitator and overview report author
- production/review of relevant evidence, the presiding procedural guidance, via chronology, summary of events and key issues from designated agencies
- material circulated to attendees of learning event; anticipated attendees to include: f the Safeguarding Partners, frontline staff/line managers, agency report authors; other co-opted experts (where identified); facilitator and/or overview report author
- learning event(s) to consider: what happened and why, areas of good practice, areas for improvement and lessons learned
- consolidation into an overview report, with: analysis of key issues, lessons and recommendations
- event to consider first draft of the overview report and action plan
- final overview report presented to the Safeguarding Partners agree dissemination of learning, monitoring of implementation
- follow up event to consider action plan recommendations
- ongoing monitoring via the Safeguarding Partners.

Further variance

There is integral flexibility within this option as to the scale and thus costs. Further, the exact nature can be adapted, dependent upon the individual circumstances, case complexity and requirements and preferences of the commissioning agency. For instance, the involvement of external agency/consultancy can vary from not at all to a full role in documents review, staff interviews and report production.

The table below is illustrative of opportunities for variance within this option and circumstances under which they may be applicable. However, the final decision will be determined by the Safeguarding Partners in consideration of the best fit and individual preferences in the light of the case in question.

There are a number of agencies and individuals who have developed specific versions of action learning models, including:

- Health and Social Care Advisory Service (HASCAS)
- Paul Tudor-Significant Incident Learning Process
- Social Care Institute for Excellence (SCIE) - Learning Together Model

Although embodying slight variations all of the above models are underpinned by action learning principles.

Advantages and disadvantages of action learning review approach are outlined below

The relative merits and drawbacks of this review approach are outlined below:

Advantages:

- significant evidence approach is much more efficient

- swiftness of conclusion and embedding the learning

Action learning approach enhances:

- partnership working
- mutual recognition of alternative partner perspectives
- collaborative problem solving
- involvement of both frontline staff/senior managers secures both strategic and operational perspectives.
- unique perspective of staff involved in the case, reflective of the systems operating at the time
- approach allows for identification of system strengths/positive practice
- learning take place through the process and there is enhanced commitment to its dissemination

Disadvantages:

- methodology less familiar to many

Peer review approach

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

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

The appointed peer team/panel should agree the Terms of Reference and specific methodology with Safeguarding Partners.

Advantages and disadvantages of peer review approach

The relative merits and drawbacks of this review approach are outlined below.

Advantages:

- objective - independent perspective to particular case/aspects of safeguarding practice
- usually via trusted sources sharing common experiences/understanding
- can be part of reciprocal arrangements across/between partnership
- very cost effective, usually no fees incurred

Disadvantages:

- capacity issues within partner agencies may restrict
- availability
- responsiveness
- where political or high profile cases deems local oversight is preferable

Multi agency practice learning review

This approach is suitable where several organisations have been involved in a case and it has been determined that there is the potential for learning and/or a need to refine or introduce policies and procedures to improve how they can work together in the future, to minimise a repeat of the incident concerned.

The methodology should be proportionate to the incident, however would normally involve the compilation of a multi-agency chronology, which is used to highlight critical areas for further examination within a facilitated workshop. The review should make best use of all available evidence including any single agency investigation reports and /or safeguarding investigations in order to maximise learning and reduce administrative burden. Normally a suitably qualified chair from the Safeguarding Partners would lead and facilitate the review and a report author commissioned from within the Safeguarding Partners who is suitably independent to the case produce a summary report and action plan.

Key priorities are ensuring the participation of all organisations in the coordination of information, participation in the workshop and in implementing the action plan.

Root Cause Analysis (RCA)

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

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

Significant Event Analysis (SEA)

This method brings together managers and/or practitioners to consider significant events within a case and analyse together what went well and what could have been done differently. Its focus is on learning which can lead to future improvements and it results in an action plan with recommendations for learning and development. Staff are brought together in a facilitated team approach.

This methodology has been used for many years in General Practice and in other areas of the NHS. The child, young person or family are not involved in SEAs, however the findings may instigate further review or investigation which should involve them.

Parallel Reviews/Investigations

Serious Incidents in the NHS (Serious Incident Framework NHSE 2015) include:

- acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in: Unexpected or avoidable death of one or more people. This includes suicide/self-inflicted death; and homicide by a person in receipt of mental health care within the recent past
- unexpected or avoidable injury to one or more people that has resulted in serious harm
- unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent: the death of the service user; or serious harm
- actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where healthcare is not taking appropriate action/intervention to safeguard against such abuse occurring; or where abuse occurred during the provision of NHS-funded care.
- abuse that resulted in (or was identified through) a Child Safeguarding Practice Review (CSPR) Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident.
- in the event of the aforementioned occurring the incident would necessitate in completion of serious incident reporting and investigation.

Domestic Homicide Reviews (DHRs)

When there has been a death of an individual of 16 years or over which has, or appears to have, resulted from violence, abuse or neglect by a person to whom s/he was related to, had been in an intimate personal relationship or was a member of the same household then a DHR will be undertaken. If the deceased person was 16 – 18 years then a CSPR will be undertaken, with the domestic violence fully considered and shared with the Community Safety Partnership. For further information see:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/97881/DHR-guidance.pdf

Mental Health Homicide Review

NHS England commissions independent investigations into homicides that are committed by patients being treated for mental illness. For further information see:

www.england.nhs.uk/publications/reviews-and-reports/invest-reports/MHHR

Criminal investigation/prosecution

Where a CSPA is to take place where there are to be criminal proceedings, Safeguarding Partners and Police will operate within the Crown Prosecution Service suggested framework for the sharing and exchange of relevant information which can be found on the CPS website:

http://www.cps.gov.uk/publications/docs/liaison_and_information_exchange.pdf.

The framework deals with the process of a CSPA and how it may affect the conduct of the criminal investigation/prosecution. Both criminal proceedings and CSAs are crucial to the effective safeguarding of children and should be carried out as expeditiously as possible and without one adversely affecting the other. The CPS suggested framework should be read in conjunction with wider CPS Legal Guidance on the CPS website:

http://www.cps.gov.uk/legal/s_to_u/serious_case_review/index.html.



Information for Rapid Review Consideration

In line with Working Together to Safeguard Children 2018 and Children Act 2004 (as amended by the Children and Social Work Act 2017). 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.

When a notifiable incident has been submitted the Safeguarding Partners are required to promptly undertake a rapid review of the case. Consideration should be given as to whether the case may raise issues which are complex or of national importance such that a national review may be appropriate.

In addition in line with Working Together to Safeguard Children 2015 and Transitional Guidance 2018 the rapid review of the case should also consider whether the case meets the criteria for a serious case review as LSCB’s are required to commission SCRs until the point at which the new safeguarding partner arrangements begin to operate.

A serious case review should be undertaken for every case where abuse or neglect is known or suspected and either:

- a) The child dies; or
- b) A child is seriously harmed and there are concerns as to the way in which the authority, their Board Partners or other relevant persons have worked together to safeguard the child.

Please provide information below that will inform the decision making as to whether the above criteria are met:

Agency involvement with name of child/children:	
Dates of Involvement:	
Name of person completing the form:	
Agency details:	

Identify the nature of your agency's involvement with the child/children/family and any safeguarding issues that you are aware of during your involvement.

At this time what factual information is known about the incident by your agency.

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Appendix 4



DARLINGTON SAFEGUARDING CHILDREN BOARD

Rapid Review Panel Meeting

Date of Rapid Review Panel:	
Present:	
Apologies:	
Date of notification to: Child Safeguarding Practice Review Panel: LSCB:	
Welcome/Reason for meeting:	
Factors about the case; as far as they can readily be established at the time of this meeting:	
Details of agency Involvement with the family and child/ren: i.e. Children Social Care, Durham Constabulary etc.	

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<p>Is there any immediate action needed to ensure child/ren and sibling safety?</p>	
<p>Has the panel identified improvements necessary to safeguard and promote the welfare of children?</p>	
<p>Are there any factors identified that indicate the case may be of National importance?</p>	
<p>Outline the panel's recommendations regards:</p> <p>Decision:</p> <p>Rationale:</p> <p>Next Steps:</p> <p>Including decisions as to whether to undertake a Local Child Safeguarding Practice Review or Serious Case Review.</p>	

<p>QA for internal use only – (tick box)</p>	
	<p>Was the date of initial notification to the Child Safeguarding Practice Review Panel within 5 working days of the incident?</p>
	<p>Was the date of the Rapid Review held within 15 working days of the notification to the Child Safeguarding Practice Review Panel?</p>
	<p>Was the decision and minutes of the Rapid Review meeting forwarded to the Child Safeguarding Practice Review Panel within 15 working days?</p>

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Appendix 5

Chronology:

Name: _____ **DOB:** _____

Address: _____

Agency: _____ **Author:** _____

Date dd/mm/yy	Time 00:00 (24hr)	Significant Event	Agency	Whose Professional/ Agency Records (Source)?	Who was involved?	Decisions/Outcome including any actions taken	Child seen/views sought: Yes/No (record the child's views)	Author Comments

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Name:	This is the name of the child
DOB:	This is the child's date of birth
Address:	This is the address of the child
Agency:	This is the agency sharing the information
Author:	This is the name of the author of the chronology
Date:	This is the date the episode event is said to have taken place (not the date of recording)
Time:	This is the time the episode event is said to have taken place (not the time of recording)
Significant Event:	The significant piece of information e.g. police log of reported incidence of domestic violence: report from school that child arrives from home hungry, unkempt and tired: missed medical appointments: allegation of non-accidental injury: anonymous referral regarding child left unsupervised: Section 47 enquiry etc.
Agency:	The record from which the information was obtained, e.g. social work record, health visiting record, school nursing record, police record, probation record, etc.
Whose Professional Records:	Details of whose professional records you are referring to i.e. source of information
Whose was involved:	Who was involved in the event, e.g. the names of each individual involved in the episode including professionals, child/ren or parent/s, carer/s other adults
Decisions/Outcomes:	Comments should inform the reader of key decisions taken, any action taken and the outcome in response to the event or episode.
Child Seen/View obtained:	Yes or No. If obtained, statement re the child's views, either expressed or observations of behaviour should be noted.
Author Comments:	To provide details of author comments relating to the episode/significant event.