



**Warwickshire Children Safeguarding  
Partnership (WSCP)**

**Guidance for Statutory Case Review Processes 2024**

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## 1. Introduction & Purpose

This guidance is for multi-agency professionals involved in the commissioning, managing and contributions to Rapid Reviews and Child Safeguarding Practice Reviews (CSPR).

The Children and Social Work Act 2017, and Statutory Guidance Working Together to Safeguard Children 2023, provides the legal framework for multi-agency safeguarding arrangements and the requirement for local areas to undertake a Rapid Review where a serious safeguarding case is identified, and such a review is considered appropriate to identify improvements to practice.

All agencies have a duty to:

- Notify the Warwickshire Safeguarding Children Partnership (WSCP) Business Team of any child safeguarding case that they consider may be notifiable under the local authority's duty to notify the Child Safeguarding Practice Review Panel.

### **Events to be notified to the Child Safeguarding Practice Review Panel (Working Together to Safeguard Children 2023 page 133).**

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:

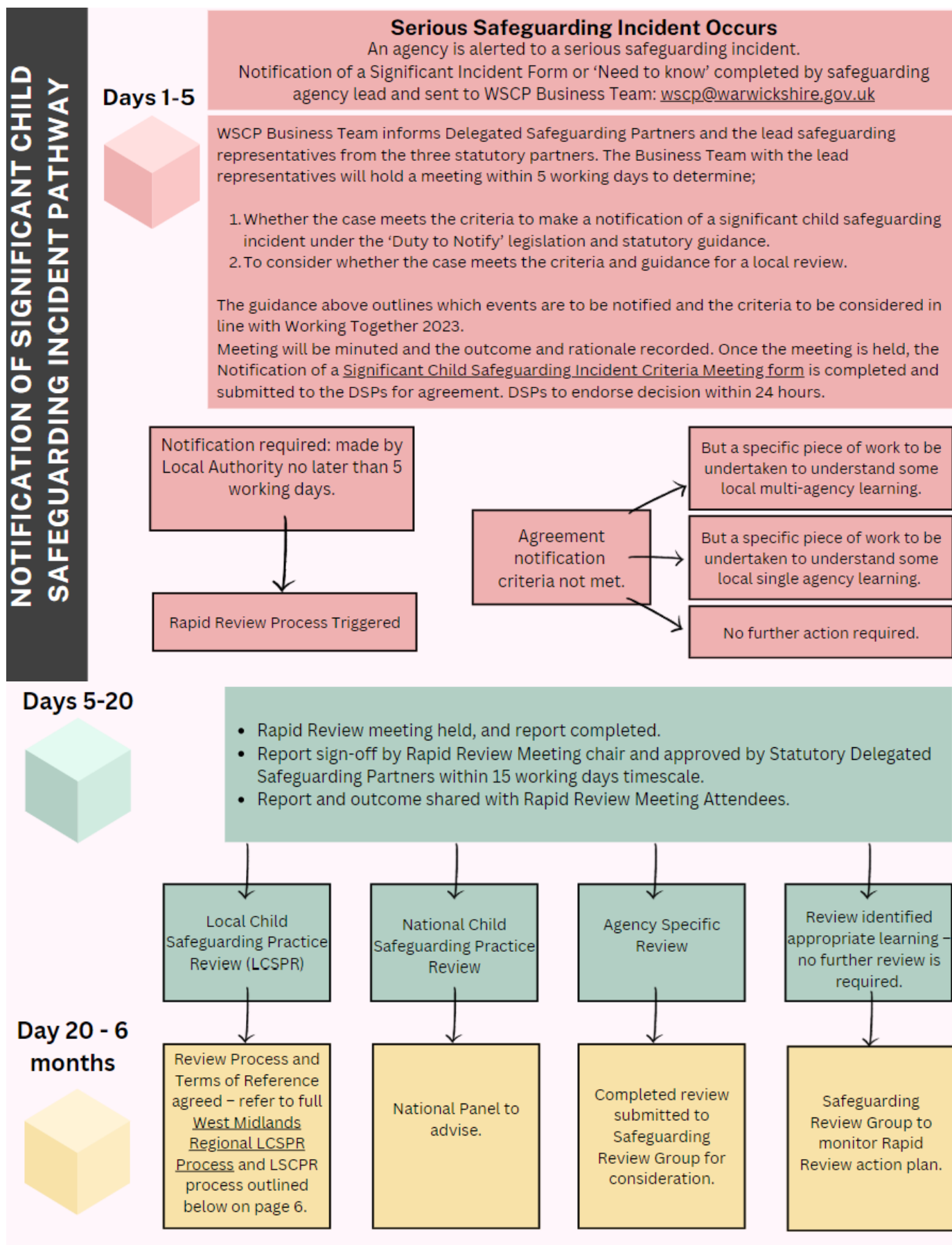
- (a) the child dies or is seriously harmed in the local authority's area.
- (b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

### **Working Together to Safeguard Children 2023 page 135, paragraph 342 outlines the criteria to be considered by safeguarding partners when deciding to notify is if a Child Safeguarding Practice Review is appropriate, includes whether the case:**

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
  - highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
  - highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children
  - is one the panel has considered and has concluded a local review may be more appropriate
- Safeguarding partners should also have regard to circumstances where:**
- they have cause for concern about the actions of a single agency
  - there has been no agency involvement, and this gives them cause for concern
  - more than one local authority, police area or ICB is involved, including in cases where a family has moved around
  - the case may raise issues related to safeguarding or promoting the welfare of children in institutional setting

**For further details regarding the criteria- please refer to working together guidance or refer to page 6 of this document.**

## 2. Notification of Significant Child Safeguarding Incident Pathway



### 3. Cross Border Working

Where a case involves services delivered across more than one safeguarding partnership or local authority, the Safeguarding Partners should liaise and agree which partnership or local authority will take the lead in conducting the Rapid Review and how other local areas will be kept informed and involved.

### 4. Statutory Duty to Notify – Notification of a Serious Child Safeguarding Incident

**Local Authorities have the following statutory duty under 16C (1) of the 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.
- b) While normally resident in the local authority's area, the child dies or is seriously harmed outside England.

**Working Together to Safeguard Children 2023 outlines the following:**

The local authority should notify the panel of any incident that meets the above criteria via the Child Safeguarding Online Notification System. It should do so within five working days of becoming aware it has occurred. Though the responsibility to notify rests on the local authority, it is for all three statutory safeguarding partners to agree which incidents should be notified in their local area. Where there is disagreement, the safeguarding partners should follow local dispute resolution processes.

Working Together to Safeguard Children 2023 also asks that local authorities must notify the Secretary of State for Education, and Ofsted of the death of a looked after child.

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

The local authority, on behalf of the safeguarding partners, has a duty to notify the panel about all serious incidents that meet the criteria. The number of serious incidents notified is **not** a reflection of local area performance. Making a notification, will ensure that learning is identified and fed back into the system to prevent future harm or death.

Although the duty to notify rests with the local authority, the decision on which incidents to notify rests with the three safeguarding partners in the local area. If a consensus cannot be reached on whether to notify the WSCP Escalation Policy will be followed. If the meeting cannot reach a resolution, the Delegated Safeguarding Partners (DSP) will be

requested to decide. In the event, the Delegated Safeguarding Partners (DSPs) disagree, Lead Safeguarding partners (LSP) will be required to decide.

**Working Together 2023 Criteria** (Paragraph 342, P135).

**The criteria safeguarding partners must consider when deciding if a Child Safeguarding Practice Review is appropriate, includes whether the case:**

- Highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.
- Highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children.
- Highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children.
- Is one the panel has considered and has concluded a local review may be more appropriate.

**Safeguarding partners should also have regard to circumstances where:**

- They have cause for concern about the actions of a single agency.
- There has been no agency involvement, and this gives them cause for concern.
- More than one local authority, police area or ICB is involved, including in cases where a family has moved around. The case
- may raise issues related to safeguarding or promoting the welfare of children in institutional settings.

Safeguarding Partners are required to promptly undertake a Rapid Review on all notified serious incidents. Where an incident has not been notified and does not meet the criteria for notification, there is no requirement to undertake a Rapid Review. However there maybe exceptional circumstances where the criteria to notify has not been met but statutory partners agree to undertake a rapid review for example if the case raises issues of importance to the local area. In such circumstances the rationale for undertaking such a review must be clearly noted.

It is also worth noting that whilst the criteria for notification to the National Child Safeguarding Practice Review Panel has been met; it does not mean that a Local Child Safeguarding Practice Review should take place following the completion of a Rapid Review and careful consideration should be given what additional learning will be gained to that identified at the Rapid Review.

On concluding a Rapid Review where learning is identified and a further review is not required, consideration should be given to whether, and how, any learning should be shared.

In the event the deceased care leaver is over the age of 18 years, local partners need to consider the criteria for a Safeguarding Adult Review (SAR). The criteria for Safeguarding

Adults Review to be considered is outlined below.

#### **What is a SAR?**

**A Safeguarding Adults Review (SAR) is a statutory requirement of the Care Act 2014 (Section 44).**

Section 44 (1), (2) and (3) of The Care Act 2014 require that a Safeguarding Adult Review (SAR) is undertaken where an adult with care and support needs has died or suffered serious harm, and it is suspected or known that the cause was neglect or abuse, including self-neglect, and there is concern how agencies worked together to safeguard the adult.

#### **The Purpose of a SAR**

**The purpose of a Safeguarding Adult Review (SAR) is:**

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguarding adults;
- To review the effectiveness of procedures (both multi- agency and those of individual organisations);
- To inform and improve local inter-agency practice.
- There should be a strong focus on understanding the underlying issues that informed agency/professionals' action and what, if anything prevented them from being able to support and protect the adult who was at risk of harm or abuse.
- As set out in the Statutory Guidance, it is important to also recognise that a SAR is to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'. The aim is that lessons can be learnt from the review and for those lessons to be applied to future practice to prevent similar harm re-occurring.

**The purpose of a SAR is NOT:**

- To hold any individual or organisation to account;
- To reinvestigate or apportion blame;
- To address professional negligence.

Other processes exist for that purpose including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation run by the Care Quality Commission (CQC), the Nursing and Midwifery Council, Social Work England, the General Medical Council etc.

It is acknowledged that all agencies may have their own internal/statutory review procedures to investigate serious incidents. The SAR process will try (where possible) to streamline and work alongside other processes, but a SAR has a clear mandate for being about learning and not about blame or accountability.

For more details regarding the SAR process- please review the West Midlands Regional Safeguarding Adult Review (SAR) Guidance or the Warwickshire Safeguarding Adults Review Protocol and Guidance.

## **5. Rapid Review**

The Rapid Review must be completed within the timescales outlined in Working Together to Safeguard Children, which is within 15 working days of the notification being made. This is then confirmed in writing to the National Panel Secretariate.

## **6. Purpose of a Rapid Review**

Rapid Reviews should establish the facts of the case as they are available, as quickly as possible, to establish if there is any immediate action or learning.

Reflection on the information shared for the review should enable the rapid review meeting panel to conclude with a recommendation to the Delegated Safeguarding Partners on whether to undertake a Local Child Safeguarding Practice Review (LCSPR).



If the decision is to commission a LCSPR, the key lines of enquiry and the questions that are to be answered by the review process should be set out in the conclusion to the Rapid Review.

The rapid review will also aim to demonstrate good practice where we identify what has been learnt and how this learning will be disseminated and acted on across the local partnership. Any such learning or immediate action should be acted upon by the local partners and monitored by the Warwickshire Safeguarding Children Partnership Business team.

A thorough Rapid Review may mean that there is no need for a separate LCSPR, and local areas can move quickly to implement learning across the system.

## 7. Rapid Review Process

Warwickshire Safeguarding Partnership Rapid Review Briefing can be accessed [here](#).

|   |  |
|---|--|
| <p><b>Day 1 -2 of formal Notification</b></p>  | <ul style="list-style-type: none"> <li>• All agencies involved are identified.</li> <li>• Agencies identify relevant attendees for the Rapid Review Meeting.</li> <li>• Rapid Review meeting chair confirmed, along with the Rapid Review Report author, Quality, Learning and Improvement Officer within the WSCP Business Team.</li> <li>• The WSCP Business Team will send out the Agency Involvement Information Gathering Template known as the Initial Scoping and Information Sharing Template (by day 2) to identified agencies with a request for information to be returned within up to 6 working days.</li> <li>• A date is set for Rapid Review Meeting.</li> <li>• All agencies should also secure all records/files in relation to the case. For some agencies where paper records are kept; it is about ensuring they are removed to a secure place where they are not accessible to agency personnel other than through a nominated representative.</li> <li>• Where records are on an electronic system and access to the records is required for ongoing case work, the following approach is agreed;             <ol style="list-style-type: none"> <li>1. - For Children and Families records on mosaic, these will be “restricted” and only accessed by authorised members of staff. Electronic records on mosaic have a data access stamp to identify who has accessed the records for quality assurance purposes.</li> <li>2.- For Warwickshire Police who work on an electronic system; all records will remain accessible and are time stamped and cannot be deleted or amended once entered onto the system.</li> </ol> </li> <li>• There is no expectation to involve families in the Rapid Review.</li> </ul> |
| <p><b>Within 6 working days</b></p>          | <ul style="list-style-type: none"> <li>• Agencies should prioritise completion of the scoping request and return the form within 5 working days. This builds in time to produce an integrated chronology of key Practice Learning Events and a Genogram in advance of the Rapid Review.</li> <li>• Completed Agency Involvement Information Gathering Template known as the Initial Scoping and Information Sharing Template are returned by agencies and collated by the WSCP Business Team.</li> <li>• Rapid Review documentation is shared with the Rapid Review Meeting Chair.</li> </ul>  |

**Around 8 working days after making the referral**



- Information is reviewed and key lines of enquiry identified.
- The Rapid Review meeting is held.
- Immediate safeguarding actions and assurance reviewed.
- Key lines of enquiry discussed, and learning identified.
- Recommendation on whether to undertake, or not, a LCSRP is agreed.

*Rapid review meeting is held between 7-13 days of receiving the referral. This will allow for analysis of the Initial Scoping and Information Sharing to help identify the key practice learning events to inform the Rapid Review, whilst also allowing sufficient time to prepare and quality assure the necessary documents for the National Panel.*

**Within 2 to 5 days after the Rapid Review meeting**



- The Rapid Review report is written and then shared with chair for comment and endorsement.
- Final draft is shared with the Independent Scrutineer and the Delegated Safeguarding Lead for the Local Authority Director of Children and Families Service, Delegated Safeguarding Partner representatives from Warwickshire Police and the Integrated Care Board for Coventry and Warwickshire. They will have 1 working day to review the Rapid Review Recommendation and endorse.

**15 working day deadline**



- The Rapid Review report is submitted to the National Child Safeguarding Practice Review Panel and copied to the members of the Rapid Review Meeting and the Delegated Safeguarding Partners Group.
- The National Child Safeguarding Practice Review Panel review the report and provide a written response to the partnership. Relevant agencies are informed of the outcome via the WSCP Business Team, which can typically be 4-6 weeks from submission to the Panel.

## **8. Initial Scoping, Information Sharing and the Securing of Records**

The purpose of the initial scoping and information sharing is to gather the basic facts about the case, including determining the extent of agency involvement with the child and family. The WSCP Business Team will send out an Agency Involvement information gathering Template currently known as the Initial Scoping and Information Sharing Template to identified agency colleagues with a request for information to be returned within up to 6 working days.

The template will confirm the specific period of time to be reviewed, as identified by key colleagues who know the detail of the case, to ensure a proportionate review. The completed templates must be quality assured by the individual agencies prior to being returned to the WSCP Business Team, and within the timescale given. While these templates will most likely be completed by a senior lead for safeguarding, it is important that the front-line practitioner is consulted and their voice included, wherever possible. The separate Agency Involvement Templates will be collated into one document by the WSCP Business Team and a composite chronology to be completed by the WSCP Business Team.

## **9. Rapid Review Meeting**

The Notification of a Significant Incident Form and copies of the Agency Involvement information Gathering template currently known as the Initial Scoping and Information Sharing Template from relevant agencies will be collated into a single document which should be shared with all those participating in the Rapid Review meeting.

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

The meeting will include representatives from each of the Safeguarding Partners and any other agencies who had significant involvement with the family. It will only be quorate if

**at least one representative** is present from each of the Statutory Safeguarding Partners.

Where there is a potential overlap with another statutory review such as Domestic Abuse Related Death Review (DARDR), a Multi-Agency Public Protection Serious Case Review (MAPPA SCR), Child Death Overview Panel (CDOP), a Safeguarding Adult Review (SAR), or Fire Service Serious Incident reviews (SIR), it is advisable to invite appropriate local experts / commissioners of the review to attend the Rapid Review meeting. But the WSCP will also liaise with other review processes, as required to seek assurances.

The Rapid Review meeting should:

- Review the facts about the case as they are known.
- Discuss whether any immediate action is needed to ensure children's safety.
- Provide proportionate challenge and scrutiny of agencies involvement in the case.
- Identify immediate learning that can be acted upon and agree how this will be shared.
- Decide whether or not to undertake a local Child Safeguarding Practice Review and record a clear rationale behind the decision.
- Consider if the cases raise any issues that are complex or of national importance such that a national review may be appropriate and if so, inform the Panel
- Consider the child's true lived experience and how can their voice be heard in the review.
- Consider how race, culture, faith, and ethnicity of the child and/or family was considered by practitioners and did cultural considerations impact on practice.
- Consider how any disability, physical or mental health issues, and any identity issues in the child and/or family impact on the child's lived experience and on practice.
- Consider whether there were any risk factors present or absent and the impact.
- Highlight good practice.
- Record actions to take forward with appropriate agencies.

A thorough Rapid Review may mean that there is no need for a separate Local Child Safeguarding Practice Review and areas can move quickly to implement learning across the system.

In some circumstances, there may be dual processes to consider the same issues for example Child Death Overview Panel (CDOP) or Domestic Abuse Related Death Review (DARDR), in such circumstances consideration should be given of other review frameworks, as relevant and liaison by the WSCP Business Team to ensure relevant learning, actions and quality assurance activity can be undertaken promptly. Where there are parallel processes underway, it is important to consider how best to reduce duplication, minimise the impact on children and families and maximise learning.

The Rapid Review Meeting should conclude with a consensus decision. Where there is disagreement, this should record as a formal minute of the meeting and be shared with the Delegated Safeguarding Partners. If the Independent Scrutineer and/Safeguarding Review Group Chair are not present at the meeting, they should be informed of the outcome of the discussion, and any proposed next steps.

On concluding a Rapid Review where learning is identified and a further review is not required, consideration should be given to whether, and how, any learning should be shared.

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

Individual agencies should notify their own inspectorate bodies as required.

## **10. Rapid Review Report**

Once the Rapid Review meeting has taken place, the agreed author will write the Rapid Review report and share for final sign off by the Delegated Safeguarding Partners. This report is shared with all members of the Rapid Review meeting to share the outcome. The report should include:

- A concise statement of what has happened.
- The key questions which emerge from an appraisal of the case.
- A detailed and sufficient analysis which addresses those key lines of enquiry. (It is important that this addresses the 'why' issues: why events happened as they did, why practitioners made certain decisions, and why children and families responded as they did).
- Clearly related learning with actions to address any weaknesses.
- Plans for dissemination and implementation of learning.

Once signed off, the Rapid Review report is submitted to the National Child Safeguarding Practice Review Panel ([Mailbox.NationalReviewPanel@education.gov.uk](mailto:Mailbox.NationalReviewPanel@education.gov.uk)), within the agreed timescale, and copied to the members of the Safeguarding Review Group and the Delegated Safeguarding Partner Group for their records.

The National Child Safeguarding Practice Review Panel will review the report and provide a written response to the partnership to advise whether there is sufficient evidence to undertake a National Review or if they agree with the decision made by the Rapid Review Meeting. Relevant agencies will be informed of the outcome via the WSCP Business Team.

If an agency specific review was recommended, this will be progressed by that agency and the results reported back to the CSPR Panel.

## **11. Rapid Review Learning**

Where the Rapid Review has concluded that no further action is required as the Rapid Review identified appropriate and proportionate learning, the Rapid Review Meeting Panel will reconvene to agree how actions and recommendations can be progressed. This may be delayed until after the response from the National Child Safeguarding Practice Review Panel has been received if they have been asked for guidance on appropriate next steps. The resulting action plan will be monitored by the Safeguarding Review Group and shared with the Assurance and Review Group to consider any quality and assurance activity.

## **12. Local Child Safeguarding Practice Review**

Safeguarding Partners are required to consider the criteria highlighted Working Together 2023 when determining whether to carry out a Local Child Safeguarding Practice Review. This criterion is highlighted above in Section 4. However, meeting the criteria does not mean a Local Child Safeguarding Practice Review must automatically be undertaken.

A Local Child Safeguarding Practice Review should be undertaken whenever a Rapid Review identifies the potential for additional learning. This may be a proportionate review. There are no other types of review needed or allowed within Working Together although

the review may use whichever appropriate methodology is agreed on a case-by-case basis.

Child Safeguarding Practice Reviews should be proportionate to the circumstances of the case and focus on the potential learning. Specifically, all reviews will be conducted in a way which:

- Reflects the child's perspective and family context.
- Considers and analyses frontline practice as well as organisational structures and learning.
- Establishes the reasons why events occurred as they did.
- Identifies clear learning that will improve outcomes for children.

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

### **13. Local Child Safeguarding Practice Review Process**

The purpose of a Child Safeguarding Practice Review is to explore how practice can be improved through changes to the system itself. Reviews should seek to understand both why mistakes were made and to comprehend whether mistakes made on one case frequently happen elsewhere. This question of 'why' is crucial and must be addressed in all reviews. While understanding what happened is important, it is critical that reviews address why events happened as they did, why practitioners made certain decisions, and why children and families responded as they did.

All agencies who provided services to the child and family during the time period specified in the Terms of Reference will be formally requested to participate in the review process. Agency engagement will be dependent on the extent of their intervention, the type of review commissioned, the chosen methodology and the specific Terms of Reference.

Each organisation should have an identified Safeguarding Lead to act as a single point of contact for the co-ordination and support of the review process. Agencies should ensure that all requests for information are acted upon in a timely fashion and practitioners are released to participate in the review. Agencies should also provide support to their staff who are affected by the case where required.

The Terms of Reference will specify the information collection and collation tools that will be used in the review. This may include chronologies, information reports or similar templates, and the use of other evidence.

Relevant agencies may be asked to complete a Chronology of their agency's involvement. They may also be asked to produce a chronology of any organisational changes which may have impacted on frontline practice during the same period. Chronologies will be used to as a tool to support analysis of events and to identify key Practice Learning Events.

Genograms should be completed to identify all key family members involved with the child/ren.

The Child Safeguarding Practice Review Panel will utilise the learning and documentation from the Rapid Review, however additional information may be requested as new key lines of enquiry emerge. These should be as few as practicable and focus on core learning. All key lines of enquiry identified by the Rapid Review process must be considered and included in the final report. The key themes should identify issues of

practice that have emerged within the case which can:

- (i) Be transposed into working with families more generally and
- (ii) Give insight into the systems which operate formally or informally within safeguarding practice.

#### 14. Practitioner Learning Event

A learning event can be used to provide a forum for frontline professionals to come together in a respectful, positive, and supportive environment to consider the circumstances surrounding the case and the reasons why actions were taken. This enables the Lead Reviewer to identify important multi-agency learning.


Agencies are expected to support the review by identifying practitioners with direct contact with the child/family and ensure that appropriate staff attend the learning event.

The Lead Reviewer will normally facilitate the Practitioner Learning Event supported by members of the WSCP Business Team and CSPR Panel. The event should consider with practitioners:

- The information compiled about the family in terms of incidents and professional interventions with an opportunity for participants to check accuracy.
- The lived experience of the child/children.
- The reasons why events and practice happened the way they did.
- The key themes which have emerged in the case.
- Any examples of good practice.
- The learning from the case and actions that should be taken to better safeguard children in the future.

Depending on the methodology used, the Lead Reviewer may wish to meet with individual practitioners prior to the Practitioner Learning Event. Practitioners who have participated in the review should be invited to provide feedback towards the end of the review process.

Below is overview of the timeline of the Child Safeguarding Practice Review:

|   |   |
|---|---|
| <b>Stage 1<br/>(Month 1 &amp; 2)</b><br> | All involved agencies will be required to identify relevant attendees for the Case Review Panel. A Chair for the Panel will also be identified.   |
|   | <b>Panel meetings will be organised throughout the process, as required. The first Panel Meeting will:</b> <ul style="list-style-type: none"><li>• Agree the terms of reference.</li><li>• Set scope and timescales for the review.</li><li>• Confirm membership for the CSPR Review Panel.</li><li>• Identify parallel investigation and point of contact.</li><li>• Identify information to be requested.</li><li>• Agree a media response statement.</li><li>• Agree if legal input is required.</li><li>• Secure dates of future meeting.</li><li>• Consider contact with family members and how this will be achieved.</li><li>• Consider reviewer terms of reference and contract terms.</li><li>• Request practitioners with direct practice are identified for the practitioner learning event.</li></ul> |
|   | The WSCP Business Team will liaise with the Independent Reviewer to identify any additional information required and support appropriate contact with the family.   |

**Stage 2  
(Month 3 & 4)**



During this period:

- A chronology of information collected will be produced.
- Additional reports and queries will be requested, and any queries addressed.
- Information will be shared with the Independent Reviewer.
- Parallel processes will be monitored.
- Key lines of enquiry and learning will be developed.
- A practitioner learning event will be organised, and attendees confirmed.

Draft Report for consideration. The CSPR Panel will provide feedback to the reviewer when a draft report is produced, to ensure accuracy of the content.

The CSPR Panel Members should consider and agree within their single agency governance:

Key learning points of the review and possible recommendations and action points.

Identify any points of dispute or gaps in learning.

Keep senior executives informed of progress.

Keep practitioners informed.

**Stage 3  
(Month 5)**



Final Version of Report submitted.

- The final Child Safeguarding Practice Review Report should be agreed by the CSPR Panel involved.
- Members should ensure that internal governance and approval processes are met.
- WSCP Delegated Safeguarding Partners have final sign off before publication of the report.

**Stage 4  
(Month 6)**



• Agree communication strategy and publication process involving the Delegated Safeguarding Partners.

• The WSCP Business Team will notify the National Child Safeguarding Practice Review Panel and Ofsted of their intention to publish.

• On the day of publication, the WSCP Business Team will upload the CSPR Report and Learning Brief to Warwickshire Safeguarding Children's Partnership and email report to NSPCC for uploading to the National Repository.

• Learning and Development Group will consider training and briefing materials.

**Stage 5**



• Panel to reconvene to agree recommendations, action plan monitoring and progression.

• CSPR Panel to oversee the completion of action plans.

## 15. Role of the Child Safeguarding Practice Review Panel

The Case Review Panel is a time limited activity operating as a group to support the completion of the Child Safeguarding Practice Review.

All involved agencies will be required to identify relevant attendees for the Child Safeguarding Practice Review; this may be the same colleague who sat on the Rapid Review Meeting.

The role of the Business Team- Quality, Learning and Improvement Officer will be to:

- Support the Independent Reviewer/author by facilitating effective panel meetings and discussions.
- Acting as a point of contact for the independent reviewer/author alongside the Business Team.
- Swiftly escalate any issues/concerns to the Safeguarding Practice Group, the Delegated Safeguarding Partner Group, and the Independent Scrutineer. This may include, but is not limited to:
  - Any safeguarding concerns relating to current case work that needs immediate attention.
  - The quality of the work being undertaken by the reviewer.
  - Any drift or delay in the review process.
  - Any dissent between an agency and the reviewer that cannot be resolved by the panel.

- With the support of the WSCP Business Team, keep the WSCP CSCR Panel members and where necessary, strategic leads, updated on the progress of the review and any challenges.

Child Safeguarding Practice Review Panel meetings will be organised throughout the process, as required.

#### **The role of the group is to:**

- Ensure the terms of reference for the Child Safeguarding Practice Review clearly identify the key lines of enquiry for the review, based on the learning from the Rapid Review.
- Work in collaboration with the Business Manager to identify a reviewer who is independent of the case.
- Agree reviewer contract details.
- Ensure the review is progressed at pace to identify learning as quickly as possible, and within the timescales expected in Working Together to Safeguard Children.
- Ensure all required, requested and appropriate information is provided to the reviewer.
- To support the reviewer to contact family members (as appropriate).
- To identify appropriate practitioners to be involved in any practitioner event.
- To be a conduit back to their organisation for any specific requests from the reviewer or review process.
- To provide feedback to the reviewer when a draft report is produced, to ensure accuracy of the content.
- Agree the recommendations arising from the review.

#### **16. Appointing an Independent Lead Reviewer**

An independent Lead Reviewer will usually be appointed to manage the review process. However, a Lead Reviewer is not a requirement and may not be needed where shorter 'proportionate' reviews are conducted.

#### **17. Family Involvement**

Family members, including surviving children, will be informed of the review, and invited to contribute unless there is a strong reason not to do so. The initial planning meeting will discuss family involvement and agree an approach that will sensitively manage their expectations and ensure they understand the process. Personal contact should be made whenever possible by the most appropriate professional and the family provided with a letter and / or leaflet to explain and introduce the review process and Lead Reviewer. Family engagement will normally be led by the Lead Reviewer and conversations should ideally take place early in the process, preferably prior to practitioner events. The Business Manager or another appropriate senior manager from the Safeguarding Review Group will do this jointly with the reviewer. However, engagement may not be possible until the outcome of any criminal proceedings. This will be judged on a case-by-case basis and involve liaison with the Senior Investigating Officer from the police.

Family members may decide not to take part in the review. All reasons for non-involvement of family members (for example, parallel investigations or the choice of the individual) should be documented in the final report.

#### **18. Local Child Safeguarding Practice Review Report**

As a minimum the final report should be focused and succinct. Content should be clear and readable to non-professionals, with an analysis that leads logically to the learning and conclusions. Reports should provide an insight into the lived experience of the child, which is developed from engagement with practitioners that worked directly with the family, wherever possible.

Reports should be written with publication in mind and in a way that avoids harming the welfare of child and vulnerable adults affected by the review. Plain language should be used.

Each report should have clearly framed questions that it seeks to answer in line with the agreed terms of reference and should:

- Provide a brief overview of what happened and the key circumstances, background and context of the case.
- Include a pen portrait of the child and family, along with a genogram.
- Only include information relevant to the scope of the review (to include all key lines of enquiry identified by the Rapid Review Meeting Panel).
- Provide an analysis of why relevant decisions by professionals were taken rather than a description of events.
- Consider the response to practice episodes.
- Consider whether any shortcomings identified are features of practice in general or system issues.
- Include how professional decision-making considered issues pertaining to equality and diversity.
- Think about what would need to be done differently to prevent harm occurring to a child in similar circumstances.
- Identify examples of good practice
- Agree what needs to happen to ensure that agencies learn from this case.
- Recommendations should be focused on practice improvement linked to the learning identified.

## **19. Quality Markers**

The Social Care Institute of Excellence / NSPCC 'Quality Markers' include seven questions that reviewers may wish to consider when drafting their report:

- Does the structure of the report make it straightforward to identify relevant analysis and findings, to assist other local areas to identify learning that is pertinent to them and to assist the collation of learning at a national level?
- Does the amount of information provided in the report satisfy the need for privacy of family members and individual staff while providing sufficient information to make accessible the analysis, in order that it can support necessary improvement work?
- Does the report contain findings and/or recommendations that reflect the areas deemed as priority for improvement?
- Do these findings and/or recommendations address explanations of practice or remain only descriptive of issues identified in how professionals handled the case?
- Is there transparency in how conclusions have been reached?
- Does the report adequately manage accessibility and explaining complex professional and organisational issues?
- Is the tone and choice of words appropriate to the review?

## **20. Child Safeguarding Practice Review Publication**

When the Child Safeguarding Practice Review has concluded the WSCP Delegated Safeguarding Partner Group will formally sign off the overview report, agree the publication date and decide on the most appropriate publication method, taking into consideration the family's best interests and any potential media coverage. The documents to be published will be quality assured by the Safeguarding Review Group and Delegated Safeguarding Partner members to ensure they are fully anonymised.

The WSCP will liaise with the relevant Communications Teams from the Local Authority, Police, Integrated Care Board to organise and agree agency specific publication statements, alongside a more general WSCP statement.

An appropriate colleague will inform the family of the intended publication and timeframe.

The WSCP Business Team will email the National CSPR Panel and Ofsted to inform them of publication date (this must be at least 7 working days before publication and allow for bank holidays).

- National Panel - [mailbox.nationalreviewpanel@education.gov.uk](mailto:mailbox.nationalreviewpanel@education.gov.uk)
- DfE - [Mailbox.CPOD@education.gov.uk](mailto:Mailbox.CPOD@education.gov.uk)

The WSCP Business Team will email the local CSPR Panel to confirm the planned publication and ask them to inform key practitioners involved in the review.

Elected members will also be notified two weeks prior to the publication of the review.

On the agreed day of publication, the WSCP Business Team will upload the CSPR Report, Learning Brief and WSCP statement to WSCP CSPR webpage ([Local Child Safeguarding Practice Reviews – \(safeguardingWarwickshire.org.uk\)](http://LocalChildSafeguardingPracticeReviews-(safeguardingWarwickshire.org.uk))) and email the report to NSPCC for uploading to the National Repository ([National case review repository | NSPCC Learning](http://Nationalcasereviewrepository|NSPCCLearning)).

- NSPCC repository - [information@nspcc.org.uk](mailto:information@nspcc.org.uk)

## **21. Child Safeguarding Practice Review Learning**

The CSPR Panel will meet to agree how the recommendations can be progressed and will formulate the action plan. The resulting action plan will be overseen by the CSPR Panel and progressed through the Assurance and Review Group.

## **22. Case Closure**

Whilst it is vital that actions identified because of Rapid Review and Child Safeguarding Practice Review learning and recommendations are completed in a timely manner, it is also important that we routinely evaluate the impact of the work. This may be through a themed audit, survey of practitioners or service users, or data evidence. The Assurance and Review Group will be responsible for identifying and undertaking this work, with results shared with the WSCP DSP and LSP and Executive Group.

## **23. Confidentiality & Information Sharing**

Case reviews will be undertaken in line with information sharing legislation and the Warwickshire Safeguarding Children Partnerships Information Sharing Agreement. The Safeguarding Partners have the formal authority to request information to support both national and local Safeguarding Case Reviews and the power to take legal action if

information is withheld without good reason.

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

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

Families should be informed and included in the Child Safeguarding Practice Review process, unless it is agreed that there could be a detrimental effect on any parallel statutory processes (such as criminal proceedings). Consent is not required, as sharing their data with partners is for the purpose of the statutory function of the Warwickshire Safeguarding Children Partnership.

All colleagues involved in any form of case review are required to keep any information obtained as a result of inter-agency co-operation confidential under restricted section of the file.

#### **24. Difference of opinion around Decision Making**

If there are any concerns about review processes, reviewer, or publication, by any member of the review process, this should initially be directed to the Rapid Review or Safeguarding Review Group Chair, via the WSCP Business Team. If a solution is not immediately clear, the final decision-making rests with the WSCP Delegated Safeguarding Partners. A full record of the discussions will be held in the minutes of the WSCP Safeguarding Review Group meeting and will be available for scrutiny if necessary. The Independent Scrutineer will mediate any discussions.

Further information on escalation can be found here: [WSCP Website Dispute Resolution Escalation Procedures](#)

## 25. Appendices

### Appendix A: Extract from Child Safeguarding Practice Review Panel Guidance for Safeguarding Partners - September 2022

Extract from pages 9 & 10, [Child Safeguarding Review Panel guidance for safeguarding partners September 2022](#)

#### Is it abuse or neglect?

The first two considerations in deciding whether to make a notification are (a) whether a child has died or been seriously harmed and (b) whether or not abuse or neglect is known or suspected, using the definition set out in Working Together 2018. Notifications must always be made if abuse or neglect is known or suspected to be a cause of, or a contributory factor to, the death or serious harm of a child. The exception to this is that the local authority must notify the Secretary of State and Ofsted whenever a looked after child dies, regardless of whether abuse or neglect is known or suspected.

The question of whether or not abuse or neglect was known or suspected has caused some difficulties for safeguarding partners. In essence we interpret this as meaning that there was sufficient reason to suspect that abuse or neglect was present and, at least in some way, caused or contributed to the death or serious harm. If the event is in itself abusive, for example the child was murdered by a parent or carer, we believe the criteria would have been met, regardless of whether or not there was pre-existing evidence of abuse or neglect.

Alternatively, if there is sufficient concern to trigger a strategy discussion, section 47 investigation, or care proceedings, or evidence to initiate a criminal investigation for possible abuse or neglect, then that indicates that abuse or neglect is at least suspected. Therefore, the criteria would therefore have been met. The local authority does not need to wait until abuse or neglect is proven to make a notification and it is for local areas to determine which cases should be submitted to the Panel based on local and contextual understanding.

We recognise that it is sometimes only through the rapid review that a judgement can be made about the strength of the relationship between the serious harm and abuse or neglect. Where the family is known to children's social care because of a recent incident or current concern about abuse and neglect, and where there has been, for example, a suicide or unexplained death, it may well be prudent to notify the event as a serious incident. This is because it may be unclear at an early stage the extent to which these broader social concerns are relevant to the serious incident in question. The rapid review process can then be used to critically examine the known facts at the time, and the extent to which there is a causal relationship between the abuse or neglect experienced and the incident under review.

#### Is it serious?

Often the judgement on whether the level of harm to a child is serious is quite straight forward. This may be because the child has a life-changing injury, long-term impairment resulting from an injury, or an injury that is clearly life-threatening - for example, requiring resuscitation or intensive care treatment. However, some incidents are not so clear. In these circumstances it is important that safeguarding partners use their professional judgement to determine whether the harm is serious.

In cases of physical injury which are neither life-threatening, nor life-changing, consideration should be given to the extent, persistence and severity of the injuries sustained and any context of wider neglect or abuse. Isolated bruises or limb fractures in infants or children would not normally be considered serious unless accompanied by internal injuries (for

example abusive head trauma, abdominal injuries) or they are of a degree or extent likely to be life-threatening or life changing.

In cases of sexual abuse, neglect or emotional abuse consideration should be given to the extent, persistence/repetition, and severity of the abuse/neglect, how this may have impacted on the child's development and well-being, and any likely long-term psychological harm, bearing in mind the child's development and any other contextual factors. A single incident of sexual abuse may result in serious emotional harm, therefore, although persistence/repetition is a factor to be considered in these cases it should not be relied on as the sole determinant of seriousness or an indicator of long-term impact.

### **Draft Templates**

[Notification of a Significant Incident Form Template](#)

[Notification of a Significant Incident - Criteria Meeting Recommendation](#)