Guidance for Identifying Serious Child Safeguarding Incidents, Undertaking Rapid Reviews, Local Child Safeguarding Practice Reviews & Individual Multi-Agency Reviews

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Amendments

Version	Date	Amendments Made	Request from (job Title)	Update done by (Job Title)
3.1	09/09/2024	Updates to reflect new Safeguarding Children Partnership arrangements - Dorset Safeguarding Children Partnership and changes made in Working Together (2023)		Project & Policy Officer, Dorset Council Project Manager, Dorset Safeguarding Children Partnership
3.2	18/03/2025	Updates to reflect learning identified in the recent rapid review process undertaken in the partnership. In addition, a section in the guidance has now been added in relation to completion of individual multi-agency case reviews (where the threshold for a LCSPR is not met).	CSPR sub-group	Project Manager, Dorset Safeguarding Children Partnership

Contents

GUIDANCE

1. Introduction

The guidance is for all practitioners, managers, senior leaders, agency safeguarding leads, and designated safeguarding leads in early years settings, schools and colleges working with children and young people across the Dorset Council area. It sets out the multi-agency process for dealing with serious child safeguarding incidents, undertaking Rapid Reviews and Local Child Safeguarding Practice Reviews (LCSPRS). The guidance is written in the spirit of Working Together to Safeguard Children (2023) whose guiding principle is:

> *'Everyone who works with children has a responsibility for keeping them safe. No single practitioner can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.'*

This guidance brings together statutory guidance Working Together to Safeguard Children 2023 with the non-statutory guidance for child safeguarding partners produced and updated by the Child Safeguarding Practice Review Panel[1] in September 2022. As set out in chapter 5 of Working Together 2023, safeguarding partners should have regard to any guidance that the Panel publishes. The Working Together to Safeguard Children guidance[2] (which is underpinned by legislation such as the Children Act 1989 and then 2004) sets out how Local Authorities should notify the **Child Safeguarding Practice Review Panel** of a serious incident.

The guidance should also be read alongside statutory guidance Keeping Children Safe in Education. **Keeping Children Safe in Education**

This guidance sets out local processes for identifying serious child safeguarding incidents, conducting Rapid Reviews, (including for cases that do not meet the criteria) and the process for undertaking local CSPRs.

2. Governance

The guidance is produced on behalf of the Delegated Safeguarding Partners (DSPs) for the Dorset Safeguarding Children Partnership[3] - the Executive Director, People –

[1] Report a serious child safeguarding incident - GOV.UK (www.gov.uk)
[2] See also The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018
[3] Dorset Council, NHS Dorset, and Dorset Police

Children Dorset Council, Assistant Chief Constable Dorset Police and Chief Nursing Officer NHS Dorset - and is managed and reviewed by the Dorset CSPR subgroup.

The statutory partners accountable for decision making are represented at the CSPR subgroup. All processes are subject to robust review and scrutiny ensuring cases that meet the criteria as a serious child safeguarding incident are identified and subject to robust review.

The Chair of the place based CSPR sub-group provides challenge and guidance to the partners. The Chair is also responsible for ensuring that learning and key messages are reported to the DSCP, and the partners are alert to thematic issues as well as examples of best practice.

The Delegated Safeguarding Partners will review and ratify the outcome of all Rapid Reviews and Child Safeguarding Practice Reviews before these are submitted back to the National Child Safeguarding Practice Review Panel. Best practice would be for the Delegated Safeguarding Partners to meet to discuss the outcome of the Rapid Review, however we recognise that this is not always possible and so an alternative to this would be for them to liaise via email to make the final agreement. Where there is likely to be disagreement between the Delegated Safeguarding Partners regarding the outcome of the rapid review, then a meeting should take place in order for a full discussion to take place to try and reach an agreement.

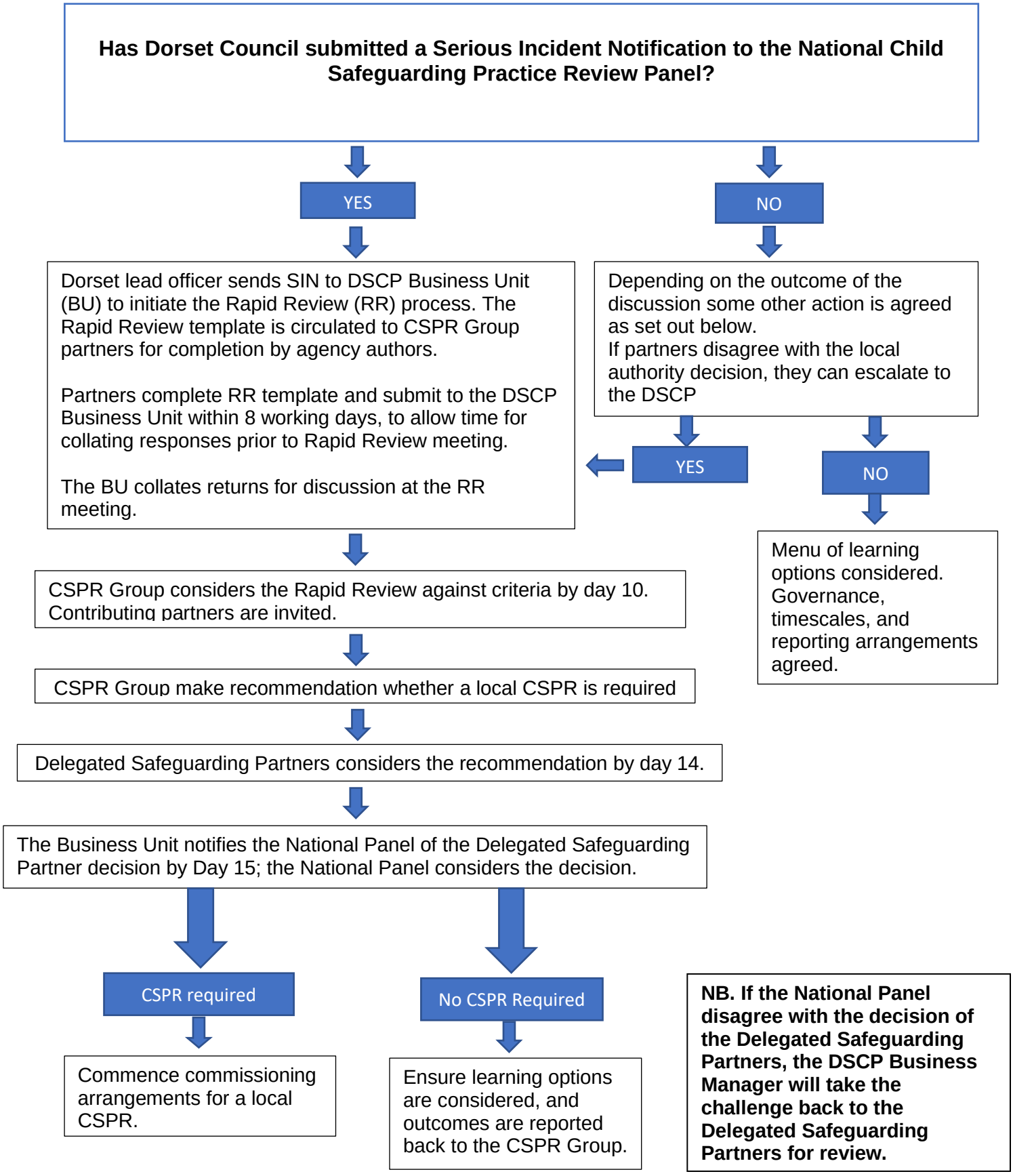
The Dorset CSPR sub-group is supported by the DSCP Business Unit. In addition to providing administrative support, the DSCP Business Unit is responsible for co-ordinating the review process, communicating with the National Panel and partners on any cases referred to the CSPR sub-group, and leading on the dissemination of learning from child safeguarding practice reviews in the multi-agency arena. Statutory partners (Dorset Council, Dorset Police and NHS Dorset), and other agencies involved in the reviews, are also responsible for ensuring key learning for their agency is disseminated to the appropriate individuals within their service.

3. Information sharing

The DSCP Information Sharing Agreement sets out the circumstances whereby information related to safeguarding children can be shared without the need for consent. This agreement is underpinned by the relevant legislation which provides the legal framework to allow this to happen.

Learning from Serious Incidents, Rapid Reviews and Child Safeguarding Practice Reviews should be shared among partner agencies as soon as it is identified. The fact that a review has not been completed should not prevent learning points from being adopted

4. Flowchart for Serious Incident Notifications, Rapid Reviews and Local Child Safeguarding Practice Reviews



5. Serious Incident Notifications

Legislation and statutory guidance place a duty on Local Authorities to notify serious child safeguarding incidents. The Local Authority should notify the panel of any incident that meets the below 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 safeguarding partners to agree which incidents should be notified in their local area. Best practice would be for the Delegated Safeguarding Partners to meet by day 4 of the Local Authority becoming aware of a serious incident, to discuss whether an incident meets the criteria for a serious incident notification. However, we recognise that this is not always possible and so an alternative to this would be for them to liaise via email to make the final agreement. Where there is likely to be disagreement between the Delegated Safeguarding Partners regarding whether the incident meets the criteria for a serious incident notification, then a meeting should take place in order for a full discussion to take place to try and reach an agreement.

Dorset Council will notify the 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[4].
c. The Council also notifies the Secretary of State and Ofsted if a Child in Care dies (reg 40 Children's Homes (England) Regs 2015.
d. 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 (it is not required to carry out a Rapid Review of Local Child Safeguarding Practice Review in these circumstances).

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social, or behavioural development. It also includes impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred, i.e., meets the criteria set out under Section 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017), which states:

This definition must be interpreted in a way which allows for the most serious incidents of abuse and neglect in all categories of harm to be identified and referred

[4] *16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017)*

for consideration (this will include sexual abuse -which includes child sexual exploitation-, neglect, physical and emotional abuse). Interpretation of the criteria must not exclude children or young people because of their age and the definition does not apply solely to children who have suffered severe physical injuries who have self-evidently suffered severe physical harm that is likely to affect their global development.

The key element here is whether there is 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, the criteria is 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 that warrants a criminal investigation for possible abuse or neglect, this is evidence that abuse or neglect is at least suspected, and the criteria are therefore met.

The Local Authority does not need to wait until abuse or neglect is proven to make a notification and it is for individual local authorities, liaising with their statutory partners, to determine which cases should be submitted to the National Panel based on local and contextual understanding.

The National Panel recognises 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 any abuse or neglect. Where the family is known to children's social care because of a recent incident or current concern about abuse or 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 at an early stage the extent to which these broader social concerns are relevant to the serious incident in question may be unclear. The rapid review process can then be used to critically examine facts, and the extent to which there is a causal relationship between the abuse or neglect experienced and the incident under review.

A referral will always be made when a child has died or is seriously injured in a children's home (including secure children's homes) and other settings with residential provision for children; custodial settings where a child is held, including police custody, young offender institutions and secure training centres; and all settings where detention of a child takes place, including under the Mental Health Act 1983 or the Mental Capacity Act 2005.

The Children's Homes Regulations 2015, including quality standards guide provides examples of incidents that are considered serious.

As set out in chapter 5 section 332 of Working Together (2023), 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. An extraordinary meeting of the Dorset CSPR group would be established to agree whether a CSPR or a learning review should be undertaken.

Dorset Council lead officers notify the Panel of any incidents that meets the criteria within 5 working days of becoming aware that the incident has occurred and notify the DSCP (Dorset Safeguarding Children Partnership) Business Manager and Business Unit so that a Rapid Review is triggered within 5 working days of becoming aware of the incident (and may also notify LSPs or local safeguarding partners outside of the Dorset areas where appropriate).

For Children in Care who die, Dorset Council would notify the Panel of the death within 5 working days of the incident whether abuse or neglect is suspected or not. The Panel will not consider the deaths of children in care where abuse or neglect is not known or suspected in respect of being linked to the death of the child or young person. It is recognised that a majority of looked after children will have experienced neglect or abuse, often as a precursor to the child being looked after. However, such abuse or neglect, unless it is felt to be directly linked to the child's death, should be considered as background information and not as indicating a requirement to undertake a Rapid Review or LCSPR. Where a looked after child has experienced recent abuse or neglect, or criminal or sexual exploitation that is linked to the death or serious harm, then a rapid review should be undertaken.

The DfE and Ofsted will take appropriate action in cases where abuse or neglect is not known or suspected to have been linked to the child or young person's death.

Information on the process to be followed using the Serious Incident Notification System can be found on **GOV.UK**.

The National Panel shares all notifications with the Department for Education (Secretary of State) and Ofsted. It is good practice for Dorset Council to do this directly.

Please refer to the Child Safeguarding Practice Review Panel in September 2022 for guidance in relation to supporting your decision-making on whether the death or harm of a young person meets the criteria for notification as a Serious Incident. The guidance provides safeguarding partners with further support around particular areas of abuse or neglect to consider in their decision-making. Any professional who

becomes aware of a potential serious incident should raise this with Dorset Council's lead officer, the Head of Quality Assurance & Partnerships.

In some cases, a 'serious child safeguarding case' may not meet the criteria for a serious incident notification but may nevertheless raise issues of importance to the local area. That might, for example, include where there has been good practice, poor practice or where there have been 'near-miss' incidents. Safeguarding partners may choose to undertake a local child safeguarding practice review in these or other circumstances, in which case they should be clear about their rationale for undertaking such a review and what its focus will be.

6. Making a Serious Child Safeguarding Incident Notification (SIN)

All potential serious child safeguarding incidents identified in Dorset Council must be brought to the attention of the Dorset Head of Quality Assurance and Partnerships who is the registered lead officer. If they are unavailable, the referrer should contact the Dorset Safeguarding Children Partnership (DSCP) Business Team for guidance. For Dorset cases this is **dorsetscp@dorsetcouncil.gov.uk**

The process for reporting a serious incident to the Panel is via the Child Safeguarding Incident Notification System is set out in the following: **Report A Serious Child Safeguarding Incident (SiN) (GOV.UK)**. The serious incident notification is submitted by the lead officer – the Head of Quality Assurance & Partnerships in Dorset Council. The Delegated Safeguarding Partners will need to agree via an extraordinary meeting (or via email if this isn't possible) that the incident meets the criteria for a serious incident notification. The Local Authority will then submit the SiN to the National Panel. If there is disagreement, then this will be escalated to the Lead Safeguarding Partners. The National Child Safeguarding Practice Review Panel will share all notifications with Ofsted and the DfE. The lead officer for each Local Authority will inform the DSCP Business Team of any request for SINs and send them copies of all submitted SINs. The DSCP Business Team will keep a record of all requests for SINs and their outcome.

If the Delegated Safeguarding Partners decides that it does not meet the criteria for a SiN then the partnership, through the CSPR group, will determine whether any other learning event is required e.g., single agency or multi-agency review, practitioner learning event etc. The CSPR group would set the terms of reference for the review and a task and finish group would then be commissioned to undertake the review.

7. Rapid Review Process

If a SIN is made the CSPR Group will hold a Rapid Review meeting within 15 working days of the SIN as set out in the statutory Working Together (2023)

guidance. The National Panel should notify the DSCP Business Manager that a Rapid Review is required within 2 working days of receiving the SIN. The DSCP will not wait for this response but will hold a Rapid Review of the circumstances surrounding a serious child safeguarding incident on the grounds that they believe the case has met the criteria for the Local Authority to submit a SiN. The date of the submission of the SiN is **day zero** of the Rapid Review process, **not** day one and timescales for the Rapid Review are calculated on this basis.

The purpose of a Rapid Review is to enable safeguarding partners to:

- gather the facts about the case, as far as can be readily established.
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately.
- consider the potential for identifying improvements to safeguard & promote the welfare of children.
- decide what steps to take next, including whether to undertake a child safeguarding practice review.

Relevant partners are requested to complete a Rapid Review report template (Appendix B) and submit this to the DSCP Business Unit within 8 days, to allow time for collating responses prior to Rapid Review meeting. For Dorset cases, these should be submitted to dorsetscp@dorsetcouncil.gov.uk

The Chair of rapid review will rotate between the statutory partners, unless there is a conflict of interest identified with the case being discussed. In that scenario one of the other statutory partners will chair the rapid review and this will be agreed between them. It is expected that agencies will have someone independent of the child or family to undertake their internal review and to also attend the rapid review to present the concerns in the report. The briefing report author will be asked to leave the rapid review following presentations of the reports, to allow for independent discussion by the panel members to agree if it meets the criteria for a LCSPR. If there are concerns about this, they should be raised with the Chair of the CSPR sub-group in advance.

Following the rapid review being held, an integrated multi-agency Rapid Review report is presented to the Delegated Safeguarding Partners with a recommendation on whether to undertake or not undertake a local CSPR.

The role of the Delegated Safeguarding Partners is to scrutinise the report decisions and recommendations, challenge partners and approve its sign off to be sent to the National Panel.

Please see below for the full timeline for undertaking rapid reviews.

Timeline for Rapid Reviews (the day of submission of the Serious Incident Notification is day zero)

Working days from notification	Activity	Lead
Day 0 (notification of SiN)	Dorset Council Lead Officer (Head of Quality Assurance & Partnerships) sends SiN to DSCP Business Unit to initiate rapid review process. Business Unit will contact the CSPR panel to alert them that a SiN has been submitted and provide the provisional date for the rapid review so that partners are aware and can prioritise in their diaries.	
Day 2	DSCP Business Team to issue the Briefing Report Template to all relevant agencies	Business Team
Day 2	DSCP Business Team sends out date of Rapid Review Meeting	Business Team
Day 8	Completed and approved Briefing Reports to be returned to DSCP Business Team	All agencies
Day 9	DSCP Business Team to send Rapid Review agenda and Briefing Reports to those attending	Business Team
Day 11	Rapid Review Meeting is held, case is discussed, and recommendations agreed	Chair of Rapid Review
Day 14	Delegated Safeguarding Partners to sign off Rapid Review Recommendations. Notification produced by DSCP Business Manager following Rapid Review Meeting to be submitted to the National Panel.	Delegated Safeguarding Partners
Day 15	DSCP Business Manager will submit the Rapid Review Recommendations Notification to the National Panel	DSCP Business Manager
Day 20	On concluding the Rapid Review, the CSPR Group will consider whether and how the review and any learning/recommendations should be shared with the child and family.	CSPR Group
Day 20	The CSPR Group to consider how the review and any learning/recommendations arising from the rapid review should be disseminated	CSPR Group

	within the partnership and with the practitioners involved.	

N.B. The days given in the left-hand column are the latest permissible; actions may be completed before these dates.

8. What is a Local Child Safeguarding Practice Review?

The purpose of a local CSPR is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.

LCSPRs seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations, or agencies to account, as there are other processes for that purpose, but instead have a focus on learning.

8.1 **Criteria for undertaking a Local Child Safeguarding Practice Review**

Working Together (2023) states that meeting the criteria of a serious incident notification does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. This should be considered on a case-by-case basis.

The criteria that the local safeguarding partners should consider when making a decision on whether a local child safeguarding practice review should be completed is 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

8.2 Implementing a Local Child Safeguarding Practice Review

On receiving the Rapid Review Recommendations Notification, the National Panel will advise the Safeguarding Partners, within 10 working days of their scheduled meeting where they will be considering the notification, whether it agrees or not with the local panel's recommendation for a LCSPR to be held. If the National Panel disagree with the decision of the Delegated Safeguarding Partners, the DSCP Business Manager will takes the challenge back to them for review.

Once a CSPR has been agreed, the Dorset CSPR Group will set up a dedicated panel to manage the review process through to its conclusion.

9. Report Author Role and Responsibilities:

The author of the agency's briefing report for the rapid review should:

- have had no operational involvement with the child or young person under review
- attend the rapid review to provide an overview of their agency's briefing report at the rapid review, including the key learning and areas of good practice
- be responsible for following up any actions identified from the rapid review from their agency, in conjunction with the CSPR panel member.

10. Panel Members Role and Responsibilities

The CSPR Panel members should:

- have sufficient seniority to be able to work at and represent all levels within their agency
- have had no significant involvement with the child or young person under review where possible (we appreciate there are some exceptions to this for example with Dorset Police members)
- be familiar with current child protection practice
- provide all information requested by the independent reviewer within prescribed timescales and in accordance with national guidance
- have unrestricted rights of enquiry and access to staff, records, and files
- ensure that all files relating to the child/the review are secured to ensure information is not lost

- ensure that the relevant staff in their agency are informed of the purpose of the child safeguarding practice review, and exercise their duty of care to staff involved, including communicating with them regarding expectations and their role in the process, the methodology agreed and the opportunities available for them to contribute to the learning
- participate in 1-2-1 meetings with any professional involved in the case, subject to methodology
- be fair in the way that the views of staff are represented
- advise the professionals involved, their agency and the Panel if any competency issues emerge because of the review and deal with this outside of the review process
- facilitate meetings with children and families, if appropriate to their role
- contribute to the analysis of practice and learning
- quality assure the draft report prior to it being finalised for sign off

11. Commissioning an Independent Local CSPR Reviewer

When a local CSPR has been agreed, the DSCP will appoint one or more suitable individuals as independent reviewers. The reviewers are independent of the organisations involved in the case and can demonstrate they are qualified to conduct reviews through a robust vetting process. The DSCP Business Manager will source CVs for potential reviewers and share these with the CSPR sub-group for consideration and agreement on an independent reviewer. The core CSPR panel members will interview the potential reviewers and appoint the most suitable.

In all cases, the Dorset CSPR Group will consider whether the reviewer has:

- Sound professional knowledge and understanding of child safeguarding and practice relevant to local child safeguarding practice reviews
- The ability to engage both with practitioners, 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 understand practice from the viewpoint of the individuals, organisations or agencies involved at the time rather than using hindsight
- ability to communicate findings effectively
- Whether the reviewer has any real or perceived conflict of interest

All independent reviewers are required to provide:

- Contact details of two referees
- Up-to-date CV, including previous experience of undertaking reviews

- details of any recent reviews conducted – ideally with links to published reports to review writing standards
- Confirmation of public liability and professional indemnity insurance
- Confirmation of registration with the Information Commissioner's Office (ICO)

Detailed information of the child/ren/family will not be provided to the independent reviewer until the above has been provided and a contract agreed.

The independent reviewer agrees the review methodology with the CSPR Group, which will be reflective, outcome focused and differentiates new learning. They will produce a local CSPR review report suitably anonymised for publication.

12. CSPR Process

The DSCP Business Team will liaise with the Lead Reviewer and CSPR Panel members to draw up a draft Terms of Reference for the review to include the scope of the review, proposed methodology and timeline. *It is expected that CSPR reviews will be completed and published within 6 months of the date of the decision to initiate a review.*

First Review Panel Meeting

The first Review Panel Meeting will agree the Terms of Reference, the methodology of the review including the types of reports and chronologies required and the timeline for the review.

The meeting will also detail how the family can be involved (see chapter 12). Agreement should be reached on how best the family should be supported throughout the Review Process. The panel meeting should consider any key milestones related to the child and family when timetabling the review process. The panel meeting should also consider public holidays when timetabling the review.

Consideration should also be given around how practitioners are to be involved in the process, including how they will be supported. This should include each CSPR panel member meeting the practitioners involved prior to the practitioner learning events to provide them with an overview of the process; including reiterating that the focus of the reviews is on identifying learning and is not about blame.

Subsequent work of the local panel

Each draft of the report will be considered and if required amendments made. Version control is important, and the DSCP Business Team will keep a copy of all versions.

Formulating and agreeing recommendations

The reviewer will propose recommendations for improvements to multi-agency system and practice and these will be set out clearly at the end of the report. These recommendations will be SMART (Specific, Measurable, Achievable, Relevant, Time Bound).

The core panel members should meet separately to ensure that the recommendations are realistic and achievable for Dorset.

The final draft report will be sent to the relevant Local Authority's Legal Services for comment, and they should have sight of the final copy of the report prior to publication.

The CSPR Panel will agree the final report and submit it to the Dorset Multi-Agency Quality of Practice and Action Group and then through the Strengthening Services Board for approval.

13. Involving Parents and Children

Children and family members are an important source of information about their lived experience of how services supported them and worked effectively together and will always be invited to contribute to a review.

Families are notified in writing and by telephone when a CSPR is commissioned with a clear explanation of the process and will be invited to speak directly with the independent reviewer as early in the process as possible, recognising potential constraints around any criminal investigations. Where a criminal investigation into the case that is the subject of the LCSPR is ongoing, there will be a need for prior agreement with the investigating officer as to how the family may be included in the LCSPR.

Written evidence provided by the children and family is treated with the same equal weight as the evidence provided by agencies.

Children and/or siblings will be communicated with via their support networks and/or through their allocated social worker.

Any notes taken during the course of the conversations with the child and family are shared with the family member to check for factual accuracy. Should there be a criminal investigation any such notes will be subject to review by the police disclosure officer to ensure compliance with the Criminal Procedure and Investigations Act 1996.

The family will be advised of the publication date in advance and sent a hard copy of the final report for their records. If family members are not involved, the reasons for non-involvement will be noted in the report, e.g., they declined and/or were prohibited by parallel proceedings.

14. Sign Off and Publication of the Local CSPR Report

In forming the timeline for completion of the review itself and then with the communication plan for the publication of the final report, the Panel need to consider relevant events or milestones for the family e.g. birthdays or anniversaries of the child's death. In addition, any bank holidays or any political events e.g. elections both locally and nationally should be factored in.

Sign-off and publication of the local CSPR final report involves four steps:

1. CSPR Panel agrees the report is complete and reflects Panel discussions and amendments prior to going to the CSPR Group for final approval
2. CSPR Group approve the final version
3. Dorset partners sign off the final report for publication
4. Dorset partners agree a publication date and advises the DSCP

In preparation for publication of the report the safeguarding partners carefully consider how to best manage the impact of this children, family members, practitioners and others closely affected by the case. They will ensure the report is completely anonymised to prevent identification of the child and family and the practitioners involved.

The DSCP Business Manager will formulate a communication plan through a planning meeting with all key partners and relevant communication teams. This will agree the communication plan including the publication date, press statements and any advance briefings.

The DSCP Business Manager sends a copy of the full report to the Panel and to the Secretary of State no later than seven working days before the date of publication. Where the safeguarding partners decide only to publish information relating to the improvements to be made following the review, the Business Manager will also provide a copy of that information to the National Panel, the Secretary of State and Ofsted within the same timescale.

Dorset Council is the lead partner for managing press statements, collaborating with relevant partner agencies. A pre-publication briefing should be produced for

Children's Services Lead Member, and the Lead and Delegated Safeguarding Partners.

Published reports will be publicly available for at least one year on the DSCP website.

15. What Happens Next?

Once the final report is signed off, the CSPR Group will meet to develop a multi-agency action plan, deriving from the review recommendations, and assign leads from their individual agencies to progress them. The action plan is monitored by the CSPR Group through to its completion.

On completion of the review actions, these are approved by the CSPR Group and signed off by the Dorset Multi-Agency Quality of Practice and Action Group (MAQPAG).

As set out in Working Together (2023), the accountability for ensuring learning from serious incidents is implemented is the responsibility of the Lead Safeguarding Partners, and the impact of local and national reviews should be evidenced in yearly reports and subjected to independent scrutiny.

16. Embedding Learning

Reference Appendix A for a menu of learning options.

The learning from the CSPR and any recommendations will be translated into an action plan and presented to the CSPR Group. The DSCP Business team will lead on this. The progress and impact of the action plans will be overseen by the CSPR group.

A 7-point briefing for a LCSPR will be formulated by the DSCP Business Manager.

The 7-point briefing will be presented to the CSPR Group for sign-off before this is disseminated and published on the DSCP website.

17. Impact on Outcomes

The completed action plan is remitted into the Dorset Multi-Agency quality of practice and action group for follow up across agencies six months later to establish what impact the review has had on the quality of practice and systems. There should be

an impact assessment tool completed six months after actions have been completed.

18. Undertaking individual multi-agency learning events or multi-agency reviews

As indicated in the last paragraph of section 6, there may be cases which do not meet the criteria for submission of a serious incident notification by the Local Authority. In other words, the below criteria set out in Working Together (2023) for a serious incident notification is not met based on the following criteria:

Dorset Council will notify the 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[5].
c. The Council also notifies the Secretary of State and Ofsted if a Child in Care dies (reg 40 Children's Homes (England) Regs 2015.
d. 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 (it is not required to carry out a Rapid Review of Local Child Safeguarding Practice Review in these circumstances).

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social, or behavioural development. It also includes impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred, i.e., meets the criteria set out under Section 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017), which states:

This definition must be interpreted in a way which allows for the most serious incidents of abuse and neglect in all categories of harm to be identified and referred for consideration (this will include sexual abuse -which includes child sexual exploitation-, neglect, physical and emotional abuse). Interpretation of the criteria must not exclude children or young people because of their age and the definition does not apply solely to children who have suffered severe physical injuries who have self-evidently suffered severe physical harm that is likely to affect their global development.

[5] *16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017)*

The key element here is whether there is 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, the criteria is met, regardless of whether or not there was pre-existing evidence of abuse or neglect.

In those cases that do not meet the criteria for a submission of a SiN, a request may be made directly to the Dorset Child Safeguarding Practice Review Group for a multi-agency learning event or a multi-agency learning review to take place for an individual child or young person and their family.

The criteria for the submission of these requests are the following:

The Dorset CSPR sub-group will consider a request for a multi-agency learning event or multi-agency learning review if the incident does not meet the criteria for a SiN, but where there is still multi-agency learning (note that requests to the CSPR group would **not** be considered for single agency learning as set out below in appendix A) identified for how a child or young person has been safeguarded by agencies, that also meets the following criteria:

a. The learning must relate to a single child (or group of siblings) under the age of 18 years old who currently reside within the Dorset Council area. N.B. if the request relates to a number of children not related to each other, then a request for a system learning multi-agency review should be submitted to the Dorset Multi-Agency Quality of Practice and Action Group (MAQPAG).
b. The incident/event or the time period being requested for review must be within 2 years of the date that the request is being reviewed by the Dorset CSPR sub-group. This is to ensure that appropriate action has been taken to promptly address learning for agencies and to acknowledge that practice and systems change significantly on an ongoing basis; and therefore, learning identified from more than two years ago is unlikely to be relevant to current practice across agencies. If a request relates to an incident that has taken place 2 years ago or more, then the statutory partners would review this against current practice to see if there is any learning identified that needs to be progressed.
c. As point B indicates, the broad areas of learning identified should be areas that have not already been highlighted and that are not already being progressed by the Partnership because of another review etc, and this can be reviewed by the statutory safeguarding partners.

In addition, the CSPR group will also consider if the case does meet the criteria for an individual multi-agency case review, the timeline for this review taking place; which will take into consideration the volume of reviews already being undertaken by the group as well as other quality assurance or scrutiny activities being delivered by the Partnership that CSPR group members are involved in.

19. Appendices

Appendix A Menu of Learning Options

This menu is intended to provide a framework for learning options in relation to cases considered by the Child Safeguarding Practice Review Group. This is not intended to be restrictive or definitive in terms of methodologies and may be added to or reviewed with time and experience. The methodology and type of learning model should be adopted to meet the specific learning potential for an individual case.

Type of learning	Rationale	Lead Officer	Timescale for completion	Methodology	Governance oversight
Local Child Safeguarding Practice Review	Meets statutory criteria	Independent Lead Reviewer DSCP Business Manager (supporting)	Six months	As required within Working Together. Proportionate and using Systems approach to include: • Professionals • Families & children	Place based CSPRG and Dorset Multi-Agency Quality of Practice and Action Group (MAQPAG)
Practitioner learning brief	Learning disseminated immediately	DSCP Co-ordinator	1 month	7-point briefing on a page	DSCP
Multi-agency learning event	Learning for multi-agency partnership but does not meet CSPR criteria	To be agreed. Either: • Senior manager in partnership • LSCG Chair • Independent facilitator	Three months	One day event with TOR and lines of enquiry set by CSPRG, with Summary of Learning report produced at completion.	CSPRG, and Dorset Multi-Agency Quality of Practice and Action Group (MAQPAG)
Focussed Multi-Agency Case Review	Learning for multi-agency partnership but does not meet CSPR criteria. Where a need is identified for a greater degree of case analysis than is possible stand-alone multi-agency learning event.	To be agreed. Either: • Senior manager in partnership • Independent facilitator • LSCG Chair	3 – 6 months	As above: One day face to face learning circle & summary of Learning Report, with some limited/defined additional material/inquiries e.g.: • Issue/event specific Chronology •Document review • Meetings with staff • Meetings with families	CSPRG, and Dorset Multi-Agency Quality of Practice and Action Group (MAQPAG)

				Scope and focus to be clearly defined by CSPRG	
Joint supervision	Key issue for consideration is way agencies are working together for cases that did not meet CSPR criteria	Independent supervisor identified in line with Joint Supervision agreement	4 – 6 weeks	One session Reference joint supervision policy and supporting docs	CSPRG
Single agency review or audit	Learning identified for single agency only	As identified by relevant agency.	To be identified by agency	In line with agency policy and practice	Governance is with Single Agency Lead.

Appendix B – Rapid Review Briefing Report Template

Briefing Report for A Rapid Review

Rapid Review Case Reference:

Please complete and return to: dorsetscp@dorsetcouncil.gov.uk

The author of this report will be invited to attend the rapid review to provide an overview of the report.

Once all agency authors have provided an overview of their reports at the rapid review meeting, these individuals will then be asked to leave to allow for the CSPR panel to decide whether a Local Child Safeguarding Practice Review should be completed.

Timeframe

Report to be completed by:

Period to cover: (but please include any relevant significant incidents outside this timescale)

Agency providing briefing:

A. PERSONAL INFORMATION

Child's name, date of birth and addresses:

Household composition - name, dates of birth and connection to the child (attach genogram if available).

Significant Others outside of the household – name, dates of birth, address and connection to the child

Significant incident:

B. Brief chronology of significant events:

Date	Name of family member	Event	Agency

Date your agency last saw the child and/or family:

C. Summary of own agency involvement:

D. Record below your analysis and consideration of the potential improvement to safeguarding/promoting the welfare of children (own agency and multi-agency)

Reflections of areas of good practice to promote (single and multi-agency) •

Reflections on practice development in your own agency •

Reflections on practice development for multi-agency working •

E. What immediate actions have been taken by your agency to ensure the safety of the child/ren and others including adults?

F. Are there remaining risks that your agency requires support with?

DO NOT WAIT FOR A RAPID REVIEW TO TAKE IMMEDIATE ACTIONS TO SAFEGUARD CHILDREN

G. Authorisation

Your agency is required to quality assure your final report before it is submitted. This will be an appropriate person within your structures who has the responsibility for assuring the quality and content of your analysis and conclusions. It is the responsibility of your

organisation to determine the appropriate level of management to undertake this authorisation

Completion and Authorisation			
Author:		**Date completed:**	
Role			
Safeguarding Lead/Senior Manager:		**Date authorised:**	
Role			

Appendix C – Request for consideration of a case by the Dorset Child Safeguarding Practice Review Group Template

Request for consideration of a case by the Dorset Child Safeguarding Practice Review Group

Following discussion with your safeguarding lead/manager, please complete and return this form to the Dorset Safeguarding Children Partnership Business Manager via dorsetscp@dorsetcouncil.gov.uk

Please refer to the following criteria for an individual multi-agency case review before submitting your request:

The Dorset CSPR sub-group will consider a request for a multi-agency learning event or multi-agency learning review if the incident does not meet the criteria for a Serious Incident Notification (please refer to this local guidance document on SiNs, Rapid Reviews, LCSPRs and Individual Multi-Agency Reviews for further information), but where there is still multi-agency learning identified for how a child or young person has been safeguarded by agencies, that also meets the criteria set out below.

Please note that requests to the CSPR group would **not** be considered for cases where there is single agency learning only.

a. The learning must relate to a single child (or group of siblings) under the age of 18 years old who currently reside within the Dorset Council area. N.B. if the request relates to a number of children not related to each other, then a request for a system learning multi-agency review should be submitted to the Dorset Multi-Agency Quality of Practice and Action Group (MAQPAG).

b. The incident/event or the time period being requested for review must be within 2 years of the date that the request is being reviewed by the Dorset CSPR sub-group. This is to ensure that appropriate action has been taken to promptly address learning for agencies and to acknowledge that practice and systems change significantly on an ongoing basis; and therefore, learning identified from more than two years ago is unlikely to be relevant to current practice across agencies. If a request relates to an incident that has taken place 2 years ago or more, then the statutory partners would review this against current practice to see if there is any learning identified that needs to be progressed.

c. As point B indicates, the broad areas of learning identified should be areas that have not already been highlighted and that are not already being progressed by the Partnership because of another review etc, and this can be reviewed by the statutory safeguarding partners.

In addition, the CSPR group will also consider if the case does meet the criteria for an individual multi-agency case review, the timeline for this review taking place; which will take into consideration the volume of reviews already being undertaken by the group as well as other quality assurance or scrutiny activities being delivered by the Partnership that CSPR group members are involved in.

For further information contact the Dorset Business Manager on 01305 221196

This is a request for an INDIVIDUAL MULTI-AGENCY CASE AUDIT (I-MACA)

Name of person requesting the audit	**Designation**	**Agency**
Name of family, family members, including dates of birth and addresses		
Agencies Involved		
Brief Family History		

Outline of Concerns Leading to the Request for an individual multi-agency case audit (*delete as appropriate***)**

Person completing request Signed	**Print Name**	**Date**
Agency Safeguarding Lead	**Print Name**	**Date**