Child Safeguarding
Practice Review Panel

Child Safeguarding Practice Review Panel guidance for safeguarding partners

September 2022

Table of Contents

Who is this guidance for?

This guidance has primarily been written for local safeguarding partners. It will also be of interest to all senior leaders and frontline practitioners involved in child safeguarding, as well as the relevant inspectorates. The guidance is particularly aimed at those involved in local child safeguarding practice reviews (LCSPRs) including reviewers, review panel members, and those responsible for decision-making around reviews.

The Child Safeguarding Review Panel ('the Panel') would like to thank everyone who responded to our informal consultation on this guidance. The Panel received helpful and insightful feedback from safeguarding partners (including practitioners) which we have listened to and have tried to incorporate as best as possible into this version.

The Panel continues to welcome feedback from safeguarding partners as part our ongoing two-way dialogue with the system and will take this into account when we undertake future updates to the guidance.

About this guidance

This non-statutory guidance is issued by the independent Child Safeguarding Practice Review Panel (the Panel) and supersedes that set out in Edward Timpson's letter of 4 July 2018 and the previous version published in April 2019. It should be read alongside the relevant statutory guidance set out in Working Together to Safeguard Children 2018.

As set out in chapter 4 of Working Together 2018, safeguarding partners should have regard to any guidance that the Panel publishes.

This guidance from the Panel:

- sets out our expectations of how the statutory guidance in chapter 4 of Working Together 2018 should be interpreted and implemented by safeguarding partners;
- provides details on the processes of notification, rapid review and local child safeguarding practice reviews, the principles underpinning decision making, and what makes for good reviews;
- provides an overview of the Panel and our role in learning and improvement;
- outlines key points of how the Panel works, including our approach to national reviews

Our intention is not to be prescriptive or offer 'one size fits all' solutions. Safeguarding partners have the knowledge and expertise to make their own decisions and be accountable for them. Instead, we are seeking to share what in our view constitutes good practice based on over 1,500 reviews of serious incidents we have seen since the Panel's inception.

At the heart of our approach is the conviction that all children have the right to grow up in an environment that is nurturing, safe and free from harm, and that we all have a responsibility to do what we can to make that a reality. We recognise that too many children continue to be harmed despite the good work that is done every day by practitioners and others to promote their welfare and protect them from harm. Nevertheless, there are situations where the actions of professionals, or failure to act by partners and relevant agencies, contribute to or exacerbate the harm suffered by children. Above all there is always more that we can learn and do to improve our systems and working practices. Reviews that are undertaken should be done with the aim of acquiring additional learning to improve practice.

Children and families involved in the child safeguarding system as well as the public rightly expect there to be reflection and improvement when things go wrong to minimise the risk of such tragedies occurring again. It is our collective responsibility to make sure this happens and is done well. We will continue to strengthen our relationships with safeguarding partners across the regions so we can make this ambition a reality for children.

Introducing the Panel

The Panel was established under the Children and Social Work Act 2017 and operates under the relevant legislation and statutory guidance. The Panel has the power to commission reviews of serious child safeguarding cases and to work with local safeguarding partners to improve learning and professional practice arising from such cases.

The Panel became operational in June 2018. Although funded by the Department for Education (DfE) and accountable to the Secretary of State for Education, it acts independently from Government. (Though it is not a regulatory body like Ofsted or the Care Quality Commission.)

The multi-agency make-up of the Panel reflects the focus on joint responsibility across safeguarding partners enshrined in law. Panel members are appointed by the Secretary of State for Education. The Chief Social Worker for children and families is a standing member of the Panel (ex officio). All members, except the Chief Social Worker for children and families, are appointed through the Centre for Public Appointments procedure.

Panel members come from diverse professional backgrounds and have extensive professional expertise across a range of disciplines. Most have long-standing operational experience within the multi-agency network with responsibilities for safeguarding children, including children's social care, police, health and schools. Individual current roles and expertise are set out here.

Underpinning the work of the Panel is its vision that **all children are protected from abuse, neglect, and harm through excellent safeguarding practice**. The Panel's mission is to provide robust oversight and leadership of learning across the child protection and safeguarding system, and this is evident through its work to:

1. **Promote** child centred practice, ensuring the voices and perspectives of children, families and communities inform learning and improvements in child protection and safeguarding practice and policy
2. **Tackle** perennial and complex barriers to effective practice
3. **Use** evidence and data to drive system improvement and learning through high quality reviews
4. **Encourage** system learning and sharing of best practice to promote the behaviours and culture necessary for excellent child protection and safeguarding practice

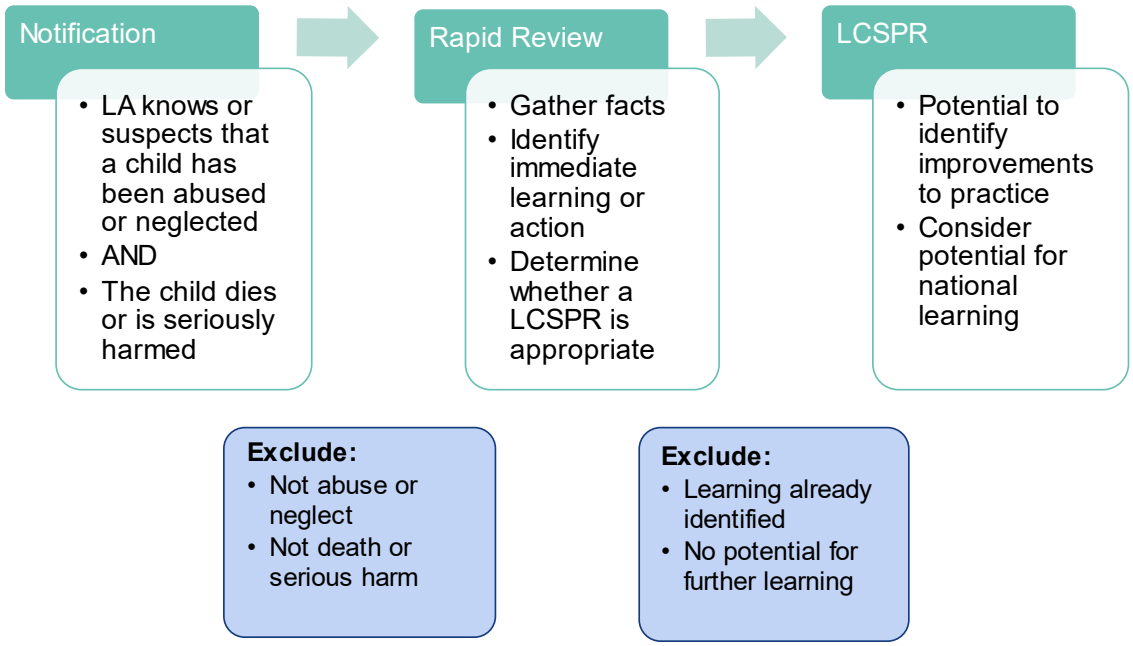
Decision making around reviews

As outlined in Working Together

2018, there are three key stages in the process of learning from serious cases (Figure 1):

- Serious Incident Notification to the Panel (shared with Ofsted and the DfE)
- Rapid review
- Local Child Safeguarding Practice Review (LCSPR)

Figure 1: Decision making around reviews



While the responsibility for notification rests with the local authority, once a case has been notified, responsibility for the rapid review rests with the three safeguarding partners. Good practice we have seen suggests that the local authority should wherever possible consult with other safeguarding partners when deciding whether to notify.

Decisions around whether to proceed to an LCSPR, and the recommendations and action plans arising from rapid reviews and LCSPRs need to be agreed by senior representatives of each of the three partners. Where responsibility is delegated within the partner agencies, those holding responsibility need to be clearly identified, have the authority to make decisions on behalf of their agency, and have clear lines of accountability.

Notification of serious incidents

The duty to notify serious incidents to the Panel sits with local authorities. All notifications are also made available to the DfE and Ofsted.

Under the Children Act 2004, if a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if (a) the child dies or is seriously harmed in the local authority's area, or (b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

The variation in the number of notifications between local authorities to some extent reflects their different socio-economic contexts and child population sizes. It is important that notifications are made because they are considered to meet the criteria, rather than because local areas are trying to meet some arbitrary number of notifications. We encourage any local area with persistently high or low notification rates to audit and reflect on its practice to ensure that all appropriate cases are being notified.

We expect all local authorities to have in place effective systems for the timely notification of all incidents in their areas meeting the notification criteria set out in Working Together 2018. This also includes ensuring that sufficient staff are registered and available to submit online notifications using the DfE's Child Safeguarding Incident Notification System and there are appropriate local failsafe processes to track originating information to inform notification. As outlined in Working Together 2018, cases should be notified within five working days of the local authority becoming aware of the incident.

It is our expectation that any case which is subject to a rapid review should have been notified to the Panel. If the Panel receives a rapid review for a case which has not been notified, we will ask the local authority to submit a notification.

Responsibility for deciding whether to notify

Where an agency other than the local authority becomes aware of an incident that appears to meet the criteria for notification, they should discuss this with their local authority counterparts to reach an agreement on whether or not to notify.

There may be instances where safeguarding partners do not initially agree on whether there is a need to notify the Panel following a serious incident. For instance, it may be unclear whether an incident appears to have met the criteria for notification, although we hope this guidance provides further help.

Discussion between safeguarding partners about cases and the decision to notify is crucial. Strong partnership working is predicated on collaboration and open dialogue. Where agreement cannot be reached through dialogue between the safeguarding

partners alone, we encourage using the support of appointed independent scrutineers to help resolve differences.

Ultimately however, the final decision on whether or not to submit a notification to the Panel following an incident is the responsibility of the local authority. This is clearly set out in Working Together 2018 and while the Panel can offer advice where appropriate, we cannot mediate or resolve differences between safeguarding partners.

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.

Thematic learning to support consideration for notification

Working Together 2018 sets out the criteria for notification as well as the circumstances that safeguarding partners should regard when considering a case. However, the Panel has observed inconsistencies in what is reported as a serious incident particularly in cases that involve looked after children, cases of neglect, sudden unexpected deaths in infancy (SUDI), suicides, and in cases of extra-familial harm. The following section of the guidance has been written using our learning about common notification themes and is intended to help safeguarding partners in conjunction with the statutory notification criteria.

Looked after children

Local authorities are required to notify the Secretary of State and Ofsted when any looked after child died. While all such cases, including deaths by suicide, accidents and medical causes must be notified, unless abuse or neglect was known or suspected to have contributed directly to the death, these cases do not need a rapid review. 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 a requirement to do 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.

Neglect

The Panel frequently receives questions about the definition and nature of neglect in determining whether to notify a particular case. Working Together 2018 defines neglect as: '*The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.'* The Panel recognises that, in general, the adverse impact of neglect on children is cumulative and typically occurs when this failure to meet the child's physical or psychological needs is persistent. It also recognises that parents, from time to time, may fail to meet a specific need of the child, but that in the context of otherwise nurturing and loving care, that is unlikely to result in any harm to the child.

The Panel has been notified of cases in which extreme incidents of neglectful care have resulted in death or serious harm, without any apparent evidence of this being a pattern of persistent failure to meet the child's needs. For example, an infant drowns in a bath having been left unattended by their parent. In these types of cases, consideration should be given by safeguarding partners as to whether the actions of the parent or carer were neglectful in and of themselves (in which case, neglect is suspected) and the outcome for the child has resulted in death or serious harm.

In other situations of neglect (or, indeed, other forms of maltreatment), there may be no single incident, but it is the cumulative effect of the neglect that is considered to meet the criteria of serious harm to the child. In such situations, the case should be notified as soon as the local authority or safeguarding partners become aware of the serious harm.

Sudden unexpected death in infancy (SUDI)

Most SUDI cases are appropriately reviewed through the child death review process and do not require a rapid review or LCSPR. Where abuse or neglect is considered to have directly contributed to the death (for example in cases of severe and persistent neglect with evidence of dangerous sleeping environments) then a rapid review should be undertaken. The Panel published a national thematic review on SUDI, *Out of Routine*, in 2020. We encourage safeguarding partnerships to reflect on the learning in that national review and how this is being acted on locally. Where an individual SUDI case reflects issues already explored in that national review, safeguarding partners should carefully consider what additional local learning is likely to be achieved through an LCSPR.

Suicides

Most suicides in young people are appropriately reviewed through the child death review process and do not require a rapid review or LCSPR. Where abuse or neglect is considered to have directly contributed to the death (for example where intrafamilial abuse or neglect or extrafamilial sexual or criminal exploitation is identified as a possible trigger factor or underlying reason for the child's suicidal thoughts) then a rapid review should be undertaken. As with other cases, an LCSPR should be considered if there is the potential for further learning.

Extrafamilial harm

We published our national thematic review of child criminal exploitation, *It was hard to escape*, in 2020. Safeguarding partners should consider the learning from that review in their consideration of any cases of possible criminal exploitation. Cases of extrafamilial harm cause particular challenges in determining whether they constitute abuse or neglect. In deciding whether to notify such cases and subsequently whether to undertake a rapid review or LCSPR, the following questions may help:

1. Is the death/serious harm caused by or directly related to actions or omissions of an adult with caring responsibilities for the child, or in a position of power or control in relation to the child?
2. Do the actions or omissions of any adult in relation to this child meet the definitions of either child sexual exploitation (CSE)[1] or criminal exploitation[2]?
3. Is the death/serious harm caused by or directly related to actions or omissions of an adult without any caring responsibilities for the child or in a position of power/control/trust in relation to the child, and without evidence of exploitation?
4. Is the death/serious harm caused by or directly related to actions or omissions of another child or young person without any evidence of any coercion or exploitation by an adult?

If the harm has been caused by an adult without caring responsibilities or in a position of power/control/trust, then that would typically constitute extra-familial violence rather than abuse or neglect. If the harm has been caused by another child, without any evidence of adult involvement or coercion, that would typically constitute child-on-child violence rather than being considered abuse or neglect.

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[1] Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. (*Working Together*, 2018)

[2] Child criminal exploitation is when another person or persons manipulate, deceive, coerce or control the person to undertake activity which constitutes a criminal offence where the person is under the age of 18. (Barnados, 2021, *Exploited and Criminalised*)

In cases of extra-familial or child-on-child violence without any evidence or suspicion of exploitation or of coercion by adults, decisions on whether to notify and carry out a rapid review should be based on whether there are safeguarding concerns associated with the case. In determining this, safeguarding partners should consider the ability of the parents or carers to provide a safe and nurturing environment for the child, the role of different agencies in supporting the child and family, whether the victim was known to children's services as well as the possible impact of multi-agency action or inaction. For example, risk assessments, school exclusion, failures to address known trauma. In any such cases, consideration should be given to the potential for meaningful learning around safeguarding in deciding whether to undertake an LCSPR.

One further consideration in cases of extra-familial harm is whether the death/serious harm was caused by or directly related to actions or omissions of an adult with caring responsibilities for the child, or in a position of power/control/trust in relation to the child within the context of a particular institution. In such cases, the safeguarding partners may wish to consider whether this constitutes institutional abuse or neglect.

However, where the harm suffered was related to the quality of care provided in the institution, rather than being caused by or directly related to specific actions or omissions of an adult with caring responsibilities for the child, or in a position of power/control/trust in relation to the child within the institution, this may be a quality-of-care issue rather than institutional abuse or neglect. Key considerations here may be whether the harm was specifically targeted towards one or more children in the institution rather than simply being poor standards/quality of care that happened to affect that child, and whether the child/children in question were particularly vulnerable, for example those with learning disabilities or those known to be at risk of exploitation.

Rapid reviews

Safeguarding partners are required to promptly undertake a rapid review on all notified serious incidents. Review timescales are set out below. Where an incident has not been notified and does not meet the criteria for notification, there is no requirement to send a rapid review to the Panel. Rapid reviews should identify, collate, and reflect on the facts of the case as quickly as possible in order to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning.

- For safeguarding partners, the rapid review should conclude with a decision about whether or not an LCSPR should be commissioned using the criteria set out in Working Together 2018.
- If the decision is to commission an 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
- Good practice is where partnerships identify what has been learnt and how this learning will be disseminated and acted on across the local partnership.

Advice on conducting rapid reviews

We have seen a great variety of rapid reviews and want to use this insight to provide advice on how to conduct the process and on the format of the final product. While we do not want to prescribe a set format or template, there are many features which contribute to a worthwhile rapid review. Ultimately what is most important is that local safeguarding partners identify and act on learning which is useful to them.

A well-conducted rapid review can form the basis of an LCSPR and, in some cases, may avoid the need for an additional lengthy review which may result in only limited additional learning. However, where a case is particularly complex, or the potential for further learning is identified, a rapid review, carried out within tight time constraints, cannot replace the rigour and transparency of an LCSPR.

We do ask as a minimum that the rapid review records:

- Date of birth, gender and ethnicity of the child who has been harmed or who has died and whether the child had any known disability
- Family structure and relevant background information on the family – include all children not just the one(s) harmed or who died. A family tree (genogram) is often helpful. Relevant information should be provided on the parents and any significant adults, including ages and any known physical or mental health problems or disability.
- Immediate safeguarding arrangements of any children involved;
- A concise summary of the facts, so far as they can be ascertained, about the serious incident and relevant context;

- A clear decision as to whether the criteria for a local child safeguarding practice review have been met and on what grounds, and if not, why not. Clear reasons are required;
- Any immediate learning already established and plans for their dissemination;
- Which agencies have been involved in the rapid review, explaining any agency omission whose involvement would be usually expected;

Important issues to consider in rapid reviews:

- What was the child's true lived experience and how can their voice be heard in the review?
- How was the race, culture, faith, and ethnicity of the child and/or family considered by practitioners and did cultural consideration impact on practice?
- How did 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?
- Were any recognised risk factors present or absent and did they play a significant part in the child's lived experience?
- Can any relevant national reviews be referenced and used to support local learning?
- Are there issues identified that are of national significance? Is a national review considered to be necessary following the rapid review? If so, why?
- Are there sufficient and sound reasons to proceed with an LCSPR? If it is decided to proceed with an LCSPR, an appropriate scope should be specified, with some identified key lines of enquiry.
- Does the review identify relevant good practice, and should this be disseminated across the system?
- Has the review identified clear agency and partnership actions to take forward, especially where there is no LCSPR recommended?

We recognise that time constraints may restrict the extent to which some of these areas are explored in significant depth. However, some of the points, such as reference to relevant national reviews, should be standard when considering the need for an LCSPR.

Please don't include:

- Internal forms used to refer cases to your review group;
- Lengthy multi-agency chronologies or events going back years – unless there is a clear and stated relevance e.g., children who have been removed from the family in the past would be considered relevant;
- Rapid reviews which are verbatim minutes of meetings – focus on summaries and analyses;
- Embedded documents. All relevant information should be included in the text of the rapid review.

Anonymised examples of rapid reviews will be published in late-2022.

It is important to remember that the purpose of the rapid review is to gather the facts, consider immediate action and potential for improvements, and decide whether to proceed to an LCSPR. The record of the rapid review is to assist safeguarding partners in meeting those purposes and keep a record of their analysis and decision making. It also assists the Panel in our advice to and consideration of the outcomes. So, the rapid review report needs to contain enough information to inform the above purposes but not so much that it obscures those purposes.

Where a case involves services delivered across more than one safeguarding partnership, the safeguarding partners should liaise and agree which partnership will take the lead in conducting the rapid review. Normally this would be the safeguarding partnership in the area where the child is usually resident. Consideration should be given to how any other safeguarding partners might be included in the decision making, including whether a joint LCSPR might be required.

Senior representatives of the three safeguarding partners should sign-off the rapid review.

Where a rapid review has already identified relevant learning and there does not appear to be any scope for further learning to be gained through an LCSPR, the safeguarding partners should outline how learning already identified will be disseminated and acted on, or how the learning outcomes have been achieved. This should be clearly expressed in the rapid review and an appropriate action plan developed.

Involvement of families

There is no expectation to involve families in the rapid review; to do so is normally neither feasible nor appropriate within the timescales. When making a notification, local authority partners should consider whether and how to inform families of the notification. On concluding the rapid review, consideration should be given as to whether and how any learning/recommendations arising from the rapid review should be shared with the family. This contrasts with the LCSPR process where the expectation is that consideration is given to how families, and, where appropriate, children, can be involved in and contribute to the review.

Rapid review timescales

Safeguarding partners should complete and submit their rapid review to the Panel within 15 working days of notification by the local authority. We recognise that this is challenging and a demanding timeframe. However, keeping in mind the nature and purpose of the rapid review, it is not unrealistic, and can help prevent drift and delays in learning and improvement. Most safeguarding partners do submit rapid reviews within the required timescale, and the quality of rapid reviews received by the Panel does not

seem to be related to the timescales. We have received very effective and comprehensive rapid reviews within the required timescale. In contrast, many of those that are delayed have been of poorer quality for example, missing important learning or not structured around key practice themes.

We recognise that to better meet the 15-day timescale and improve the quality, safeguarding partners may send the Panel a rapid review which has significant information pending, for example, toxicology results, criminal charges, or a long-term prognosis. In most circumstances, though, a rapid review can still be completed, not least because it is the multi-agency working which is the key focus i.e., what happened between agencies *before* the incident. Practice prior to the incident can still be reviewed and supplemented, should new information shed further light on how best agencies can work together in the future.

If there are extenuating reasons why the rapid review cannot be completed within 15 working days, please notify the Secretariat NationalReviewPanel@education.gov.uk.

Local Child Safeguarding Practice Reviews

Based on the reviews we have seen to date (as well as undertaking our own national reviews), we have developed the following advice on conducting and completing LCSPRs. These are suggestions to help safeguarding partners with their commissioning of reviews. As with the advice on conducting rapid reviews, we do not want to prescribe a set template or criteria-based approach to conducting an LCSPR. The advice below is intended to provide pointers to good practice and effective reviews.

Deciding whether to conduct an LCSPR

- It is for safeguarding partners to determine whether an LCSPR is appropriate, considering that the overall purpose of a review is to identify improvements to local practice and wider systems. Just because an incident meets the criteria for notification in Working Together 2018 does not mean there is an automatic expectation to carry out an LCSPR.

- Safeguarding partners need to be clear from the outset what the benefit would be of conducting an LCSPR following on from a quality rapid review. Rapid reviews should always set out a very clear rationale for doing an LCSPR and should be explicit about the key questions that the LCSPR would seek to answer.

- Good practice LCSPRs identify new learning that is not yet available in local safeguarding systems, or they tackle perennial problems that need further or perhaps different attention. An LCSPR does not automatically explore learning from a rapid review in more detail although partners may decide to initiate an LCSPR for this reason.

- If a child has been notified and the rapid review subsequently identifies that the notification criteria is no longer met (for example, there is no evidence of abuse or neglect, or the harm suffered was deemed not to be serious), the safeguarding partners may nevertheless decide to carry out an LCSPR if they deem that there is still potential for further learning and a clear rationale for doing so.

- It is important to remember that the responsibility for decision making rests with the safeguarding partners therefore it is important to document who participated in the rapid review to ensure that the executive leads ‘own’ the decision. Where that responsibility has been delegated it is important to be clear on the lines of accountability. While the views of the independent scrutineer are valuable, they do not replace the responsibility of the safeguarding partners.

- Occasionally the Panel may question the decision to conduct an LCSPR if we do not feel there is sufficient justification or information about need for further review. Similarly, the Panel may question a decision not to conduct an LCSPR if it feels that the rapid review has not adequately explored the learning or if there may be further

learning to be gained from an LCSPR. This is explored further under the section *How the Panel Works*.

Approach

- Working Together 2018 provides guidance on commissioning a reviewer or reviewers for an LCSPR. The key consideration is whether the reviewer has the appropriate knowledge and expertise of the child safeguarding system to undertake the review. The reviewer should be able to take a critical and authoritative stance to identifying multi-agency learning. To that end the reviewer should have no real or perceived conflict(s) of interest – i.e. be independent of the case. Safeguarding partnerships may consider using their own capacity to undertake LCSPRs, as appropriate, and provided the person has suitable skills in applying a systems approach to undertake reviews as outlined in Working Together 2018.

- We know that sometimes safeguarding partnerships propose undertaking an 'alternative learning review' or use other terminology to describe different approaches to further review. We support and encourage different methodologies and approaches to review; however, any further review of a case should be referred to as an LCSPR and should meet the requirements of an LCSPR, including the appropriate involvement of practitioners and families and the expectation that the report will be published within 6 months.

- Any decision to undertake a further review of the case should be carried out as an LCSPR. This is different to the dissemination of learning arising from a rapid review. Where a rapid review has identified important learning, such that further review of the case is not needed, then consideration should be given to how that learning is disseminated – for example through practitioner learning events or practice briefings – such approaches do not require further review of the case and should not be referred to as reviews.

- A methodology should set out the principles and approach to learning and the methods and tools used to answer the agreed aims and questions. The methodology should be clear and should describe what was done and how. Whatever methodology is used, every effort should be taken to ensure the review gets to the 'why' behind events, not just the how and the what.

- The scope, aims, and terms of reference of the LCSPR should be determined at the start and should be specified clearly in the final report. They should stem from the learning identified in the rapid review. While undertaking an LCSPR, alternative lines of enquiry or methods might be required and any amendments should be reflected in the final report.

- The best LCSPRs start with the key lines of enquiry, questions a review is seeking to answer, and provide evidence and analysis of what the scope and focus of the review

will be. Key lines of enquiry should be few in number (we would suggest no more than 3 or 4 key questions) and focused on the most important issues for learning. This should be accompanied by a concise summary of the circumstances and background of the case in order to lend appropriate context to the reflection and learning of the LCSPR that will follow. As stipulated in Working Together 2018, all reviews should reflect the child's perspective and the family context. This does not require a descriptive account of all events; the aim is to provide appropriate and meaningful context, sufficient to illuminate the major theme or themes arising from the case.

- Key practice episodes can be used to analyse significant events in the chronology and to focus on the role of agencies at these times. Key lines of enquiry can also help to determine questions for agencies and families and can help structure conversations, so the valuable insight is extracted. Structure and prompts can help get to the core of the practice issues, but conversations should also allow for unstructured contributions and reflection.

- Our expectation is that the lived experience of a child and where possible and appropriate, their voice, should be dominant throughout a review. LCSPRs should specifically consider these aspects in their analysis of the circumstances of the case, their appraisal of practice, and in the methods applied to the review.

- It is imperative that an LCSPR considers the characteristics of a child's identity – such as race, ethnicity, gender, disability. It is important than an LCSPR discusses if and to what extent the characteristics and cultural background of a child and/or family may have impacted professional decision making.

- Racial, ethnic, and cultural issues are pivotal factors and should be given proper weight when exploring the reality of children's lives in LCSPRs. Since its inception, the Panel has considered a number of LSCPRs that did not give due consideration of the child's personal characteristics, for example their race, sexual orientation, gender, ethnicity or disability.

- A request to agencies for information about the case, policy or procedure can be made to enhance understanding or a particular episode. This can be a useful mechanism for securing formally and quickly further information.

- An LCSPR should not necessarily be limited to reviewing the specifics of one family and a specific incident but rather be used to also explore broader aspects of practice, to ascertain whether there are systemic practice issues to be addressed. Study of the particular incident creates the opportunity to study the whole system, both what is working well and what is not, looking at the underlying issues that are influencing practice more generally.

- Too many LCSPRs are written in the style and approach of 'old style' Serious Case Reviews (SCRs); they often have overly long chronologies, use SCR methodologies

and approaches that do not engage in sufficient depth with system problems, nor do they explore why issues and practice problems may have occurred and what therefore needs to change as a result. This approach often leads to unacceptable delays in completion and publication along with bland and ineffective recommendations. We encourage creative thinking around how best to approach reviewing each case in light of the identified key lines of enquiry/ review questions.

- An LCSPR can benefit from bringing in wider relevant evidence related to the case. For example: the context of the local area, data and analysis relating to agencies and services, national or international evidence and learning from other LCSPRs and/or national reviews.

- Where there are large numbers of professionals involved in an incident from a range of agencies their involvement should be carefully summarised and focus on key practice episodes to avoid overly long LCSPR chronologies.

- Human error, where it is identified, should be a starting point for exploring any deeper systemic issues, and not the conclusion of the review. Asking, why did the person act in the way they did and what was the environment and context in which they were operating, while avoiding an over-focus on what happened is more likely to lead to effective learning and recommendations. This does not in any way detract from the importance of those in positions of authority, particularly senior leaders, and managers, taking responsibility for the systems and structures and how those are worked out, nor of all professionals taking responsibility for their own actions.

Intersectionality

Intersectionality is the interconnected relationship of social categorisations such as race, gender, and sexual orientation together with individual vulnerability and adversities suffered by the individual. It is important to consider the potential to learn from issues of ‘intersectionality’ at each stage of the process – particularly when considering the usefulness of an LCSPR.

This is because some children feature more (or less) in the statistics, for example black boys and increased incidents of serious youth violence in London. Racism, bias, stereotyping, or cultural misunderstanding operate at the individual, institutional and societal level, both consciously and unconsciously – which in turn may result in some children being more likely to come to the attention of child protection services, while others less likely to receive the right service. Equity is an important consideration for our services, not only in the individual actions we take but also in the process of our decision making.

Interface with criminal investigations and proceedings

- The LCSPR process can often run in tandem with ongoing criminal proceedings and as such safeguarding partners sometimes take the decision to delay the LCSPR process until the conclusion of the criminal proceedings which may be several years after the serious harm or death of a child has occurred.

- However, the existence of criminal proceedings should not automatically lead to a decision to delay the LCSPR process. The criminal process and LCSPR process consider fundamentally different things. An LCSPR looks at system learning, and the criminal process is looking at individual culpability. The timeframe under consideration is also often different, as the LCSPR will be focused on multi-agency activity/inactivity before the death or serious harm. Whereas the criminal process will be focussed on what happened at the time of the death or serious harm. Therefore, when considering whether or not to delay the LCSPR process, safeguarding partners should give careful consideration to the proposed key lines of enquiry. Where the learning is restricted to systemic weaknesses in multi-agency practice, then the LCSPR [process and the implementation of learning should not be delayed.

- Where there are potential overlaps in relevant timelines under consideration in the criminal and LCSPR processes it may still be possible conduct the LCSPR (with clear agreed key lines of enquiry) and implement the learning but delay the publication of the LCSPR.

- The Crown Prosecution Service has issued guidance about how any risks to criminal proceedings can best be managed and mitigated. https://www.cps.gov.uk/publication/protocol-liaison-and-information-exchange-when-criminal-proceedings-coincide-child & Major-Crime-Investigation-Manual-Nov-2021.pdf (college.police.uk)

- Where there are concurrent criminal investigations, there may need to be negotiations around the scope and the methods used in the review. Negotiation with police and/or CPS at the outset about what the safeguarding partnership intends to review and how it will be undertaken will, in most cases, allow the LCSPR to complete without interfering with a criminal investigation or prosecution.

- In criminal proceedings the availability of witnesses is a commonly stated problem, but this should not prevent LCSPR work being undertaken, with any gaps in learning from not undertaking particular interviews being addressed later. Often safeguarding partnerships wait many months, if not years, to speak to families or extended families only to be told that they do not wish to engage. Therefore, the review focus should be on prompt learning embedded into system and practice improvement.

- Concerns about compromising witness statements can be avoided in rapid reviews and LCSPRs by using methodologies that enable reflection, analysis and system

learning that do not focus on individual practitioner action or inaction but helps create the conditions for improved practice relevant to the context of the case.

- Where safeguarding partners are concerned about the timeline for publishing an LCSPR prior to the conclusion of criminal proceedings, please contact the Secretariat who can facilitate dialogue with Panel

Final reports

- The purpose of an LCSPR is to identify improvements to be made to safeguard and promote the welfare of children. The final LCSPR report should therefore reflect this. It should contain enough information to provide a clear context for the learning and recommendations and to reflect the perspective of the child and the family, and the views of practitioners. It should focus on analysis of both practice and system leadership issues, should clearly identify any learning arising from the review, and, where appropriate, include clear and relevant recommendations that can be linked to achievable and meaningful action plans.

- It is important, where possible, to identify whether any of the issues identified in an LCSPR resonate more widely and therefore should be disseminated across the system to support effective local practice. We have also found that reviews rarely identify or consider issues that highlight the conditions in which practice takes place. These can often be overlooked in favour of practice improvement themes but can arguably provide even richer learning from LCSPRs.

- Any recommendations should be few in number and focused on improving practice, rather than simply increasing bureaucracy with more procedures and rules, monitoring and control. Reviews should avoid making recommendations that are vague and general, repeating what should be standard practice, or that seek assurance around issues that should have been covered in the review itself.

- With good lead time it is important to establish who should see the report, when and how. Support for family at the time of meeting and after seeing the report should be considered. The process of reading the report needs to meet the needs of families, allowing time in advance of publication to ensure they are aware of the findings and recommendations. To note this is not about changing the reported facts - which are sometime contradictory - but about reflecting nuance in language which is sympathetic to family context.

- LCSPRs need to be owned and signed off by the three safeguarding partners and any recommendations linked to action plans that are specific, achievable and meaningful so it is clear who will take responsibility for their implementation, how, and in what timeframe, and how the impact of any recommendation will be measured. Changes to practice emanating from LCSPRs need to be led by safeguarding partner leaders. Systems need to be put in place locally so that there is assurance that practitioners

have adopted the required changes in practice.

- There is an expectation that all reviews will be completed and published within six months of the agreed decision to undertake an LCSPR. Circumstances such as ongoing criminal or other investigations are not, of themselves, a reason to delay completion, and any likely delays beyond six months should be discussed with the Panel.

To illustrate the points above, we have developed some framework questions which the Panel use to consider whether an LCSPR is of good quality:

1. Is there a clear rationale for the scope of the LCSPR based on the analysis from the rapid review? Is the review focused? What are the key lines of enquiry that the review is seeking to address?
2. Has the chosen methodology helped with exploring the identified themes?
3. Where relevant to the focus of the review, does it give a sense of the daily life of the child/children?
4. Where relevant to the focus of the review, does the report consider the race/ethnicity and any disability of the child/children? Does it interrogate potential direct or indirect experiences of discrimination?
5. Where relevant to the focus of the review, does the report explore intersectional identities of the child/children?
6. Where relevant to the focus of the review, does the report show an understanding of the distinct context for the child/children (background, culture and history)?
7. What is the quality of analysis and interpretation of findings? Does the review go beyond simply identifying 'what went wrong' to consider the impact of organisational context and leadership, and any system issues underlying practice?
8. What is the quality of identified learning points, recommendations, and any linked action plans?
9. Is the report timely and with a quality structure (including independence of author, accessibility, usefulness, length etc)?
10. Are there implications for local/national practice and/or policy?

LCSPRs and publication

There has been, and continues to be, a great deal of debate about the transparency of the child protection system in England. While it is right that there is transparency through publication, it is also right that we should not place any child at risk of any harm in upholding that principle.

The Panel is frequently asked to consider non-publication of LCSPRs mostly on the grounds that to publish would in some way jeopardise the safety and/or wellbeing of children. As a Panel we do consider these matters most seriously and balance representations against the presumption in statutory guidance and the Children and Social Work Act 2017 that reviews will be published.

The fact that an individual or family might be identified is not, in and of itself, a reason not to publish. It is important that relevant steps are taken to anonymise the case and to protect personal and sensitive information. However, we recognise that in most cases, a determined investigator might be able to identify the case, no matter how thoroughly it has been anonymised. What is important is that the review should not contain information that could be harmful to any individual if made public. Since the purpose of the review is to identify and learn lessons to improve practice, the focus of the review should be kept on learning those lessons, with sufficient context to enable the lessons to be meaningful but avoid unnecessary sensitive information.

We have suggested on several occasions that the safeguarding partners remove the very intimate and personal detail of a family's life to reduce the sensitivity of publication. We have seen successful examples of where, following such a re-write, it has been possible to publish the review. Only very exceptionally have we agreed to an LCSPR not being published locally.

Working Together 2018 states that "safeguarding partners must send a copy of the full report to the Panel and to the Secretary of State no later than seven working days before the date of publication". However, this does not always align with the fortnightly cycle of Panel meetings and at times the publication date has fallen before Panel has had the opportunity to discuss a LCSPR and the recommendations it makes. This is particularly pertinent to those reviews which are likely to attract public and/or media interest and also where safeguarding partners have made national recommendations – especially recommendations about the Panel - which we may wish to consider and discuss with partners prior to publication. At present our only option is to formally write to safeguarding partners following publication.

Therefore, based on our learning, we would like to suggest that where an LCSPR is likely to attract public and/or media attention, or it contains national recommendations for the Panel, we would welcome early discussion with safeguarding partners to give us the opportunity to consider the implications of the proposed recommendations. This is voluntary and we accept and have discussed possible consequences with the Department for Education; primarily that it might create a short delay in publication.

The interface with other statutory processes

The Panel recognises that a serious incident may trigger more than one statutory review process. It remains important for safeguarding partners to organise locally how these can successfully combine while still meeting the core purpose of each.

Under Working Together 2018 there is discretion as to when a local child safeguarding practice review should take place and who does it. This will create greater flexibility in designing a single review mechanism, which still meets a variety of specific statutory obligations.

It is possible for partners to work together to deliver on a report that cover the necessary requirements of, for example, a Domestic Homicide Review or Safeguarding Adult Review as well as a child safeguarding review. This will be appropriate where separate review processes arise from a single or linked incident, for example children are living in an abusive and neglectful home and their mother is killed by their father. When undertaking a joint report it is important to ensure that the key requirements of both processes are clearly identified and met.

CAFCASS

We have seen cases where there has been involvement, at some point, with the family court system but engagement with the Children and Family Court Advisory and Support Service (Cafcass) is not noted in a rapid review or LCSPR. The absence of this engagement can mean a loss of learning, for the partnership and for Cafcass. We would like to encourage safeguarding partners to involve Cafcass in review processes where possible and appropriate to maximise learning potential across the whole safeguarding system.

Safeguarding partnership yearly reports

(Also known as Safeguarding Partnership Annual Reports)

Working Together 2018 requires safeguarding partners to publish an annual report at least once in every twelve-month period as part of their partnership arrangements and send copies to the Panel (NationalReviewPanel@education.gov.uk) and the What Works Centre for Children's Social Care (WWCSC).

Panel analysis of safeguarding partner yearly reports has indicated that there is a very low level of compliance with this submission requirement. For 2020-21, as of 1 June 2022, only 65 out of 132 Safeguarding partner yearly reports - less than half - had been sent to either WWCSC or the Panel.

Yearly reports should reflect and analyse how chairs and safeguarding partners demonstrate the leadership of local safeguarding partnerships, for example how strategic priorities are determined and how learning is disseminated, as well as compliance with Working Together 2018.

To help safeguarding partners meet the requirements set out in Working Together 2018 for producing a yearly report, and to ensure that it is easier to share learning and experience between different local areas, we have suggested the following questions to think about when preparing reports. These are designed to be helpful prompts, developed in conjunction with WWCSC, based on the reports we've seen to date.

- What were your priorities for the last twelve months? How were these decided and by whom? What activities took place to take forward these priorities?
- What was the evidence base behind these activities and interventions?
- What was the impact of these activities on children, families and professionals (from early help to looked after children and care leavers) and how was this measured?
- Where there has been little progress or things have not gone well, what lessons have been learnt?
- How has learning from activities (including from rapid reviews and local or national child safeguarding practice reviews) been used across the partnership?
- Have there been any resulting improvements from activities (including from rapid reviews and local or national child safeguarding practice reviews)?
- What independent scrutiny/scrutineer arrangements are in place and why have these been adopted? How successful have they been?

- What role has children and families' feedback had in your planning and activities?
- What training has taken place and how is the impact of training being measured (beyond the numbers of people attending)?

How the Panel works

Our operating principles

We are bound by the Seven Principles of Public Life and operate according to The code of conduct for board members of public bodies. Our Terms of Reference can be found here.

If Panel members have any personal or business interests relating to a specific case or decision which comes before the Panel, they:

- declare this to the Secretariat as soon as they are aware of it;
- absent themselves from any Panel discussion or consideration of the case(s) or decision; and,
- ensure that they make no personal or business use of any insights gained through sight of Panel papers on the case(s) or decision.

Preparation for Panel meetings

The Panel has a responsibility to identify and oversee the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance. In discharging this function, we work with local safeguarding partners to identify such cases and we maintain oversight of the system of national and local reviews. The Secretariat receives all notifications of serious incidents from local authorities and the subsequent rapid reviews from safeguarding partners.

We want to make decisions as quickly as possible but sometimes we need to discuss matters directly with local safeguarding partners. This avoids getting into protracted correspondence which can rarely substitute for the nuanced discussions needed in some of the more complex cases.

Safeguarding partners should also feel able to contact the Secretariat for points of clarification, although the Secretariat cannot advise about the interpretation of statutory guidance. It is for safeguarding partners and statutory agencies to secure their own legal advice.

Panel decisions and records of meetings

All meetings are quorate comprising at least four members of the Panel. In exceptional circumstances, or where agreement cannot be reached by a majority, the decision will rest with the Chair or, in his/her absence, his/her nominated Deputy.

We currently consider approximately 20-40 cases each Panel Meeting with a mixture of rapid reviews and LCSPRs. Our ability to manage the volume of casework is greatly

helped by the quality of the information given to the Panel. Sometimes it is not possible for the Panel to make a decision because we do not have all the information we need, in which case we will write to ask for further information, or where a discussion might be more expedient, a member of the Panel will make arrangements to speak to the relevant safeguarding partners.

On occasion when relevant information is missing, the Panel may offer a provisional view, pending receipt of the missing information, about whether or not an LCSPR should be commissioned. This is most likely to happen where the overarching circumstances of the serious incident are clear cut.

While the Panel will offer our views on the decisions made, ultimately, the decision to proceed to an LCSPR is a local decision, for which local safeguarding partners are accountable.

Occasionally there is a difference of opinion between the Panel and local safeguarding partners about whether or not an LCSPR should be commissioned. The Panel does not have the power to require local safeguarding partners to undertake reviews, but should we feel so strongly that a particular case requires scrutiny either as a case in its own right, or as part of a themed review, we may commission a national review. In these circumstances, the Panel will aim to work collaboratively with the local area.

We believe that written correspondence with safeguarding partners following Panel consideration of a case is crucial. We have taken into account feedback from local areas and adapted our approach to make sure Panel letters are of maximum benefit for safeguarding partners. We will write letters back to local safeguarding partners confirming our views on the case and to offer feedback on the decision making, analysis and learning, or to request further information. These letters act as a record of the meeting, and we aim to respond within 15 working days of receiving a rapid review. Where a conversation with safeguarding partners would be helpful and/or is necessary, this may impact when we issue a letter to safeguarding partners in response a review.

The role of the Secretariat

We are supported by a Secretariat comprised of civil servants from the Department for Education. The Secretariat reports to, and acts on behalf of the Panel. There is a separate team within the Department for Education that supports and advises Ministers on serious child safeguarding cases and monitors the Panel in terms of how it fulfils its responsibilities as set out in legislation and statutory guidance. This is important to maintain the Panel's independence. The Secretariat is the normal channel for communication between local areas and the Panel, senior civil servants and Ministers, and between the Panel and other internal and external stakeholders. The Secretariat can be contacted at Mailbox.NationalReviewPanel@education.gov.uk

Communications

We want to continue to work with you as we identify improvements that should be made to safeguard and promote the welfare of children. This will require an ongoing dialogue through the representative groups for safeguarding partners.

Since its inception, the Panel has sought to increase its communication and engagement with stakeholder bodies and safeguarding partnerships. We want to build on the work-to-date by increasing the reach of our communications channels and providing more opportunities for engagement. This is achieved by issuing a monthly newsletter, quarterly publication of practice briefings and Panel-run events such as regional roundtables which gives the Panel the opportunity to hear directly from safeguarding partners.

To support this ambition, we have identified a Panel member to link to safeguarding partners in each of the nine English regions to support discussions on issues of mutual interest. They are available for safeguarding partners to contact (via the mailbox) and discuss referrals, reviews, and any other questions you may have.

We will continue to assess and adapt our approach to communicating and discussing learning in a way that is agile and responsive to changing circumstances.

The data we collect

The data we collect help us to understand the common themes and issues we are seeing consistently.

We also collect a range of other data that allows us to interrogate the system, understand how well processes are working, and measure (to a certain extent) the influence we are having on local decision-making. This includes:

- the number of Serious Incident Notifications we receive;
- the primary cause of death and serious harm in the cases we review;
- how many rapid reviews are received within the 15 working day timescale and our response time to local areas;
- how often we agree or disagree with local area decision making and our ability to influence a change in approach; and,
- how many notifications we receive that do not meet the criteria for a local child safeguarding practice review.

Our annual reports present some of these data, and are available here: https://www.gov.uk/search/transparency-and-freedom-of-information-releases?organisations%5B%5D=child-safeguarding-practice-review-panel&parent=child-safeguarding-practice-review-panel

Information requests

The Panel may require any person or organisation or agency to provide them, a reviewer or another person or organisation or agency, with specified information. This must be information which enables and assists us to perform our functions, including those related to national child safeguarding practice reviews.

The person or organisation to whom a request is made must comply with such a request and if they do not do so, we may take legal action against them.

Commissioning national reviews

The criteria and guidance when deciding whether it is appropriate to commission a national review of a case, or cases, are set out in Working Together 2018. The national reviews we commission may be thematic reviews based on types of cases or systemic issues that we see frequently or are identified as important national issues, or they may be individual case reviews where a particular case is significant in terms of its complexity or implications for national learning.

An important part of setting up the review process is a dialogue between the Panel and the local areas affected. This helps make sure the scope and methodology of the review maximises the learning potential and the most efficient of resources, including the time of those involved at a local level.

We have appointed a pool of potential reviewers who can undertake national reviews, a list of whom can be found here. To enrich and expand the pool, we will continue to run recruitment exercises periodically. However, if we consider there to be no approved reviewers with availability or suitable experience for a particular review, we may also decide to select a person from outside the pool to undertake or support that review.

The review into the tragic deaths of Arthur Labinjo-Hughes and Star Hobson was published in 2022 and eight national recommendations were made alongside local recommendations in Bradford and Solihull. The Panel has been working with Government departments following publication to consider the reviews recommendations including a new model of peer support for local safeguarding partners. This guidance will be updated in 2023 to reflect ongoing work.

About this publication:

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