SSCP Rapid Review Process

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Introduction

This document sets out the arrangements by which Stockport Safeguarding Children Partnership (SSCP) will determine when to trigger a Rapid Review process or another appropriate alternative case review process. It highlights its statutory duties, overall process for running a Child Safeguarding Practice Review (CSPR) and how the Partnership will commission such work. The core process it will utilise for all case reviews is set out in the document.

It should also be noted that the SSCP is concerned with reviews of significant cases, some of which will become a CSPR: others may become reviews commissioned by the SSCP when potential learning is identified. Where learning is identified but the case does not meet serious harm criteria alternative processes will be considered. This will be identified within the document.

The CSPR process will be flexible depending on the nature and complexity of a case and will mirror the approach taken by Stockport Safer Partnership (SSP) in relation to a Domestic Homicide Reviews (DHR).

How to refer a case for consideration

To support all partners to recognise and refer cases the SSCP has developed a single case referral form (Appendix A). This form allows a partner to outline the case and propose the process they feel is required from:

1. A Rapid Review – potentially leading to a Child Safeguarding Practice Review
2. A Practice Review – potentially leading to a multi or single agency learning process
3. Case Escalation – potentially leading to case mediation

This form is submitted to the SSCP Partnership Manager (via lsb@stockport.gov.uk) who, with the oversight of the Practice Improvement Partnership (PIP), will determine the most appropriate learning pathway. This will be based on guidance and definitions provided by Working Together 2018 in relation to serious harm and notifiable incidents. All referrals and decisions will be reported to the PIP who will act as a scrutineer to the pathways selected. However, ultimate authority and decision making will rest with the three statutory partners.

Once the Business Manager has, in conjunction with the referrer and partners, selected an appropriate pathway the case will progress within set timescales (see Appendix B for an overview). The referrer will be updated as to the progress of the case if taken forward into any form of learning review. It is vital that those making referrals ensure that all relevant information is included at the time of the initial referral to prevent any unnecessary delays in decision making.

It is expected that each individual agency reviews its own referrals before they are submitted to the SSCP team. This is to ensure that all referrals have been sufficiently considered by a senior manager before the learning review pathway is triggered. The SSCP referral process is for cases meeting specific criteria, which will be explored in later sections, and senior managers should ensure it is only these cases raised to the attention of the partnership. For example, those that are notifiable incidents, cases of "serious harm", unresolved escalation cases and cases where a multi-agency practice review is necessary to identify lessons for practice.

The purpose of the SSCP Learning Review process is as identified within Working Together as: *"… to identify improvements to be made to safeguard and promote the welfare of children…Reviews should seek to prevent or reduce the risk of recurrence of similar incidents."*[1]

[1] Working Together 2018: Chapter 4, paragraph 3-4 - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

Type of Case Reviews

A referral to the SSCP can trigger a range of different responses. The information below aims to help clarify which pathway may be used and when.

Rapid Review

Working Together 2018 identifies that where a case is a "serious child safeguarding case" then partners must make arrangements to identify, commission and oversee arrangements for that review process. These cases are clearly identified within the statutory guidance as distinct from our day to day practice by certain terms. Firstly, "serious harm". This term is defined as:

"… serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health…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."

If local partners identify a case where serious harm has occurred and abuse and or neglect is suspected, then this case must be notified to the National Panel[2] and consideration given to whether or not a local review is required. Case Notification is explained further in the next chapter.

Therefore, not every case referred to the SSCP will lead to a Rapid Review as these are held only for those cases meeting this distinct criteria. A Virtual Panel, consisting of the three statutory partners, will consider these referrals and determine if a Rapid Review will be triggered. In these cases, a Rapid Review Report will be returned to the National Panel within 15 working days of the referral being received.

A Practice Review

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

A practice review will be considered by the PIP when Rapid Review criteria is not met. They will review the referral to identify if there is multi-agency or single agency learning. If they identify the potential for lessons about how we work together locally then they will identify a lead to take forward a practice review. The form of this review will be determined based on the individual case needs and proportionate for the learning involved. For example, a desk top review may be proposed for those cases where learning is limited to short periods of time and less complex case elements. In contrast for complex cross border cases then a more complex professional de-brief process may be utilised. Learning Together Reviews may also be taken forward with the original participants in the case to review identified aspects of the case as part a reflective practice session chaired by the Safeguarding Lead/Manager, (e.g.

[2] The National Panel refers to a body established in 2018 to oversee all Serious Child Safeguarding Reviews.

Designated Nurse, Safeguarding Education Lead) or other such suitable person, including an independent facilitator.

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

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

Escalation

In some instances, it may become apparent that the issues being raised relate to operational decision making and require a response in a very short time frame. For example, there may be disagreements as to the threshold at which a case is being managed. It is not appropriate for a learning review to be conducted in these instances as they cannot manage case risk. Therefore, the Partnership Manager will refer these into the escalation process for a swift response.

A Learning review process may become appropriate once the immediate escalation matter has been dealt with. A learning review can offer a restorative process for practitioners to understand how the processes and systems created barriers to effective working. However, this should be considered after an escalation has been resolved.

No Further Action

In some cases, it may be appropriate to take no further action with a case referral. If individual agencies have reviewed their cases before referring them in, then the number of cases not being identified for further action should be reduced. However, there may be occasions where a referral is received and the SSCP do not see a purpose to taking a review forward. For example, if a case reflects learning from a recently commenced review it may be determined that there is no purpose to reviewing the case in addition. Similarly, if a review has just concluded and the learning not yet been shared then it may be determined that the lessons have been identified but action has not yet been implemented.

If agencies are dissatisfied with the decision reached by the SSCP then they may challenge this through the escalation process.

Notification of a Serious Safeguarding Incident

There is a duty on local authorities to notify serious incidents to the National Child Safeguarding Practice Review Panel

A decision about whether an incident is serious should be made using the definition set out in Working Together 2018:

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

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

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

Notification must always be made if abuse or neglect is a cause of, or a contributory factor to, the serious incident or where it is suspected. Whilst it is the Local Authority that carries this duty to report, partners are under a duty to inform the safeguarding partners of any incident that they think may meet these criteria. This can be done using the referral form at Appendix A. The SSCP Partnership Manager will then ensure the statutory partners determine if the incident is notifiable and ensure that an online report is made.

The online report will be made via https://www.gov.uk/guidance/report-a-serious-child-safeguarding-incident It will be made within 5 working days of the incident being identified.

The Virtual Panel

The Virtual Panel represents the safeguarding partnership that carries the responsibility to determine if a Rapid Review is required once a case has been referred. It must represent the three statutory partners and within Stockport may also include the following roles:

- Designated Nurse, Safeguarding – CCG
- Director of Operations-Stockport Family
- Detective Chief Inspector-GMP Stockport

The panel will use the criteria defined in Working Together 2018 and their locally drafted guidance document (Appendix C) to consider whether a case/incident meets the threshold for a Notifiable Incident and/or a Rapid Review. The panel will make this decision through virtual communication; email; skype; telephone discussion or a meeting if time permits. The Partnership Manager SSCP is responsible for ensuring the communication between the panel members is timely and focused.

In the event that the virtual panel agrees that the above criteria is met, Stockport Local Authority, through the Head of the Safeguarding and Learning Unit or a delegated officer, will notify the National Panel within five working days of becoming aware of the incident via the online reporting portal. This notification will then be shared by the National panel to the Secretary of State, Department for Education and Ofsted as required.

Rapid Review Process

If the Virtual Panel determine that a Rapid Review is required, then the safeguarding partners should promptly undertake a Rapid Review of the case. This will be for those cases which meet the threshold of a Notifiable Serious Incident or the virtual panel has taken a decision that a Rapid Review is the most appropriate way forward. The review should aim to:

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- Gather the facts about the case as far as they can be readily established at the time.
- Discuss whether there is any immediate action needed to ensure children's safety and share learning appropriately.
- Consider the potential for identifying improvements to safeguard and promote the welfare of children.
- Decide what steps they should take next, including whether or not to undertake a Child Safeguarding Practice Review.

All partners/agencies who had knowledge of the child will be required to contribute to a Rapid Review.

A practice review single agency summary template (Appendix D) will be sent out to designated safeguarding leads in identified agencies within **two working days** of the virtual panel making a decision to hold a rapid review. All agencies should secure all records/files in relation to the case through safeguarding leads/managers in their service area and a process agreed to ensure access is appropriate to those professionals involved in ongoing service delivery to the child/carers.

Agencies should return the completed template to the safeguarding unit business support officer within **8 working days.** This will enable the Rapid Review Panel Chair to review and construct an overview of the case for the panel using the Chairs Notes document (Appendix F).

The safeguarding unit business support officer will circulate the completed template **one day** prior to the Rapid Review Panel meeting if time allows. Members of the panel will be drawn from the core members of the Practice Improvement Partnership which will include:

- Greater Manchester Police (GMP)
- Stockport Council Children's Services
- Stockport Clinical Commissioning Group
- Stockport NHS Foundation Trust
- Pennine Care NHS FT
- Any other manger/practitioner that the virtual panel think would be appropriate to attend the information sharing part of the meeting.

A Rapid Review meeting will be convened between **7 and 13 working days** of the Virtual panel agreeing it's notifiable. Panel members will utilise the review criteria laid out in the National Panel guidance to consider the case and identify if the need for a review is evident. The meeting will be structured to ensure all the relevant criteria is considered (see Appendix E for draft agenda templates).

The virtual panel may decide that the threshold for a Notifiable Incident/Rapid Review is not met and that the Rapid Review process is not appropriate but agree that an alternative learning process should be considered. In this case the SSCP Partnership Manager will submit the case to the PIP to agree a process for the learning.

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

Decision making on initiating local and national reviews

The criteria which the local safeguarding partners must take into account when deciding whether to initiate a Child Safeguarding Practice Review or an alternative learning process include whether the case:

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

Safeguarding partners should also have regard to the following circumstances:

- Where the safeguarding partners have cause for concern about actions of a single agency.
- Where there has been no agency involvement, and this gives the safeguarding partners cause for concern.
- Where more than one local authority, police area, or clinical commissioning group is involved, including in cases where families have moved around.
- Where cases may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.

These criteria is embedded into the Panel paperwork (Appendix C, E & F) to ensure that all relevant criteria is discussed in light of the information shared by agencies.

Meeting the criteria does not mean that safeguarding partners must automatically carry out a local CSPR. If the learning identified is already known about and changes in practice are in progress, then safeguarding partners may decide not to carry out a review. They may, also initiate a different type of learning review. Conversely some cases may not meet the definition of a 'serious child safeguarding case' but nevertheless raise issues of importance to the local area, e.g. good practice learning opportunity, so safeguarding partners may choose to initiate a local Child Safeguarding Practice Review.

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

What a completed Rapid Review Report should include

On completion of the Rapid Review, the chair and SSCP Partnership Manager should sign off a Rapid Review report and share with the National Panel their decision on whether a CSPR is appropriate. If this is the case, consideration will be given to appropriateness and arrangements for commissioning an independent chair and/or author.

Within this report there will be reference to:

- Whether or not the case in question has been considered against the criteria set out in Working Together (2015) if an LSCB is still in operation or Working Together (2018) if local safeguarding partners are now in place.
- Immediate safeguarding arrangements of any children involved.
- A concise summary of the facts, so far as they can be ascertained, about the serious incident and relevant context. This should give sufficient detail to underpin the analysis against the Working Together criteria but does not require lengthy detailed chronologies of agency involvement that can obscure the pertinent facts.
- A clear decision as to whether the criteria for a CSPR has been met and on what grounds, and if not, why not. Clear reasons are required.
- A recommendation on whether a National Review would be considered necessary, and if so, why.
- Any immediate learning already established and plans for their dissemination.
- Potential for additional learning.
- If the decision is taken not to proceed with a CSPR or local child safeguarding practice review, a summary of why it is thought there is no further learning to be gained.
- Which agencies have been involved in the Rapid Review, explaining any agency omission whose involvement would be usually expected?
- Who has been involved in the decision-making process?
- Relevant identifying details of the child and family.

Scrutiny & Challenge

Under Working Together (2018), the criteria for local child safeguarding practice reviews offers greater flexibility for partners to consider how learning is best generated within a new safeguarding arrangement. External scrutiny of this decision making is offered by the National Panel through the submission of any Rapid Review Reports.

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

If a CSPR decision requires review, either because a local review is indicating the need for a national review or new information becomes available that suggests a learning review is now required, then the SSCP will reconsider. This will be taken forward by the SSCP Partnership Manager in conjunction with PIP members and proposals made to the SSCE for a final determination. All such reconsiderations will be reported to the National Panel once a determination is made.

The Partnership Manager will do a desk top review of all Rapid Review decisions at 6 and 12 months to see if any further information has become available that might have impacted on the original decision making.

The Purpose of a Child Safeguarding Practice Review

The key aim of any review remains as set out in the following legislation/guidance:

- Working Together 2018[3]
- Domestic Violence, Crime and Victims Act (2004)[4]
- Child Safeguarding Practice Review Panel: Practice Guidance 2019[5]

In order for a CSPR to be effective and in line with the above guidance it should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children.
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
- Is transparent about the way data is collected and analysed.
- Makes use of relevant research and case evidence to inform the findings.

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Therefore, the focus will be on understanding practice and not to hold individuals or organisations to account. There are other processes that exist to undertake that role, such as employment law and disciplinary procedures, and these should be used when that is sought. These processes can be run in parallel or subsequent to one another and decisions regarding the appropriate timetabling will be made on a case by case basis.

The Practice Improvement Partnership (PIP) will moderate the work of the CSPR as the review progresses and will ratify the final report before presentation to the Stockport Safeguarding Children Executive (SSCE).

The PIP will also:

- Quality assure all safeguarding learning reviews, agreeing terms of reference and appointing leads/chair.
- Co-opt professionals onto to the panel as appropriate.
- Sign off the final report/learning review.

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[3] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[4] http://www.legislation.gov.uk/ukpga/2004/28/contents

[5] https://www.gov.uk/government/publications/child-safeguarding-practice-review-panel-practice-guidance

Working Together 2018 and the National Panel Guidance[6] offer clear guidance on expectations for reviews and timescales. The expectation of the SSCP is that this report and learning is available no later than 6 months after the decision to initiate a review is made. This is to ensure that all learning remains relevant to current practice. Therefore, the partnership will endeavour to produce a concluded review within 6 months. There may be challenges to this, such as criminal proceedings or Coronial processes. Should these impact on the review process, then steps will be taken to share information and continue the review as far as is possible without damaging these other processes nor limiting the review itself. Any early identified actions will be commenced to avoid delay where service / multi agency working practices can be improved.

Conducting the Review

A sub group of partners may be convened to undertake a specific CSPR on behalf of the PIP. The sub group will have delegate authority to oversee the progress of the review. Its membership will be determined on a case by case basis dependent on the nature and context of the case. Once a decision has been made to conduct a review, the chair and members of the review sub group are responsible for preparing the draft Terms of Reference (ToR), which should be proportionate to the circumstances of the case.

If an independent chair/author is appointed, then they will be responsible for the final decision on the suitability of the CSPR's TOR and they are to be agreed at the first meeting of the sub group. The TOR may, however, need to be revisited as the review progresses and as new information is identified. The review sub group chair will agree any amendments to the TOR.

As part of the terms of reference, the Chair should appoint lead individuals or agencies who will act as a:

- Designated advocate for engaging with family members and friends.
- Contact point for responding to media interest about the review in conjunction with Stockport Council's corporate communications team.

Please note: All contact with the Coroner must be sent through Stockport Council legal department.

The review sub group chair should as far as possible ensure that the review process is a learning exercise in itself for all those involved in the case.

Independent Chair/Author

Working Together 2018 does not specify the need for an independent chair for a CSPR so this will depend on the complexity of the case, the review model selected and other local considerations. If an independent chair/author is appointed their name/s should be shared

[6] National Panel Guidance document - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793253/Practice_guidance_v_2.1.pdf

with the National Panel. If the National panel offer advice and/or guidance on the appointment of an independent Chair or Author, then this will be taken into consideration.

The independent chair/author should be an appropriately experienced individual who is not directly associated with any of the agencies involved in the CSPR. They will be responsible for effectively leading and coordinating the CSPR sub group and for quality assurance of the final report.

Consideration should be given to the skills and expertise required to effectively chair a CSPR and in relation to the nature of the specific case in focus. The identified individual should have, as a minimum, the following appropriate core skills:

- Strong leadership and ability to motivate others.
- Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics.
- Collaborative problem solving experience and knowledge of participative approaches.
- Ability to find and evaluate best practice.
- Good analytical skills and ability to manage quantitative and qualitative data.
- Knowledge of safeguarding adults.
- Ability to write for a wide audience.
- An understanding of the complexity of the health and social care arrangements and an awareness of issues which are complex or of national importance such that a national review may be appropriate.

Methodology

The CSPR sub group should agree with their reviewers the method by which the review should be conducted, taking into account the principles of the systems methodology. The methodology should provide a way of looking at and analysing frontline practice as well as organisational structures and learning. The methodology should be able to reach recommendations that will improve outcomes for children. All reviews should reflect the child's perspective and the family context.

The review sub group chair will establish an agreed timetable of review sub group meetings in accordance with the required timescales of the review and set specific parameters, including timescales for the completion of chronologies, conversations and any other learning event which includes further exploration of practitioners' views.

The review panel chair will maintain contact with the Safeguarding Children's Partnership Manager of all parallel review or investigation processes and to ensure that any coordination and joint commissioning arrangements are effective.

The chair of the review sub group should ensure that regular updates are obtained regarding services being provided by any agency to meet the safeguarding or other needs of individuals who are subject of the review.

Where there is an on-going criminal investigation, the review sub group chair will ensure that early and regular contact is made with the senior investigating officer to ensure appropriate processes are being followed. This relates particularly to any planned interviews with family members, practitioners and managers and must take into account that any one of these people may be a potential witness or even defendants in a future criminal trial.

Involvement of family members, friends, and other support networks

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

Family members can include:

- Siblings
- Parents
- Carers
- Grandparents
- Other significant family members identified from the Family Association Network/ Genogram.

As a minimum, family members should:

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

The final overview report

The CSPR overview report brings together the learning and themes identified from the review and will analyse and comment on the effectiveness of practice and the systems used to safeguard and promote the welfare of the child and/or adult.

The chair of the review sub group has responsibility for collating the report and the report should:

- Provide a brief overview of what happened and the key circumstances, background and context of the case. This should be concise but sufficient to understand the context of the learning and recommendations.
- An analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report
- A critique of how agencies worked together and any shortcomings in this.
- Whether shortcomings identified are features of practice in general
- What would need to be done differently to prevent harm occurring to a child in similar circumstances
- Be written in a succinct and focused manner with the emphasis on recognising and sustaining good practice as well as identifying how and where practice can be improved in the future.
- Identify action that agencies or services have already undertaken in response to learning and what else needs to happen to ensure learning is embedded.
- Form a conclusion as to the effectiveness of local practice to safeguard and promote the welfare of the child/and or adult.

The report should also:

- Have clearly framed questions that the review seeks to answer.
- Have an executive summary of no more than 2 A4 pages.
- State clearly learning points and steps for learning.
- Be written in such a way that it can be published with minimal redaction.

The CSPR overview report should firstly be presented to the review sub group. This provides an opportunity for the chair and review sub group to quality assure the document, reference the identified learning and ensure an opportunity for the findings to be challenged where necessary. The report should already have identified areas of learning and the author/chair should have had access to relevant past/current action plans so that recommendations/actions can be put into the context of wider learning across the partnership.

It is the responsibility of the sub group to work with the author and chair to develop an action plan which takes account of the wider learning improvement cycle. Once agreed the chair of the review sub group should present the report to the PIP.

It will be the responsibility of the PIP to identify and agree how practice challenges or recommendations from the CSPR will be responded to and what action is needed by individual agencies or from a multi-agency perspective.

Action plans

A draft action plan should be included as part of the final report and should include:

- A timeline for publication of the report should be developed and where possible a date identified.
- Action taken to share the findings of the report with the family members.
- Practitioners who contributed to the review and learning event should have been briefed about the content of the final report and should already be aware of the findings, as the process of the review is an important element of the, learning which will be more effective if those involved are partners in the process.
- As far as possible, this principle should be applied to family/carers/friends who have participated but it is understood that this will be on a case by case basis.
- How it will share the lessons learned, and practice impact with the wider workforce in the Stockport area.

Once the CSPR report and action plan have been agreed, the report will be endorsed and signed off by the SSCE. The action plan will be regularly reviewed, and its impact evaluated using existing SSCE processes via the PIP.

The findings from any CSPR should be reported in the SSCP Annual Report and what actions it has taken or intends to take in relation to those findings. Where the SSCP decides not to implement an action, then the Annual report must state the reason for that decision.

Communication/Media Strategy

The chair of the PIP in consultation with the independent author/chair, where appointed, will consider appropriate publication of the report on a case-by-case basis. Discussions about publication will be held with the individual(s), their family or carers (where appropriate) and if there are arrangements made by the SSCP Partnership Manager to upload the report onto the SSCP web site and release a statement informing partners and the National Panel.

Since the Local Authority is the lead agency, media and communication issues will usually be co-ordinated by the council's communications team. This will be done in collaboration with the communications teams of the other agencies involved, alongside agreed representatives of the partnership.

Learning from CSPR

The value of CSPRs is in the learning derived from them. As much effort should be spent on acting on recommendations as on conducting the actual review. Recommendations should be SMART: Specific, Measurable, Achievable, Realistic, and Timed.

The following should help to secure maximum benefit from the review:

- Conduct the review in such a way that the process is a learning exercise.

- Consider what information needs to be disseminated (how and to whom) in the light of a review.
- Be prepared to communicate both examples of good practice and areas where change to practice is required.
- Focus recommendations on a small number of key areas with specific and achievable proposals for change and intended outcomes.
- Ensure robust monitoring of the resultant action plan to ensure identified changes/improvements are implemented and embedded.
- Communicate with the local community and media to raise awareness of the positive work of services working with children.
- Make sure staff and their representatives understand what can be expected in the event of a CSPR.

The National Child Safeguarding Practice Review Panel

The purpose of the National Panel is to operate independently from government and local areas to identify changes that will create an improved practice system for children and families that reduces child abuse and neglect. They came into being in June 2018 and are responsible for determining whether or not the criteria for a National review is met. The panel will take into account whether the case:

- Highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.
- Raises or may raise issues requiring legislative change or changes to guidance issued under or further to any enactment.
- Highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children.

The Panel should also have regard to the following circumstances:

- Significant harm or death to a child educated otherwise than at school.
- Where a child is seriously harmed or dies while in the care of a local authority, or while on (or recently removed from) a child protection plan.
- Cases which involve a range of types of abuse.
- Where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.

The panel will also consider a range of evidence when considering their decision, including inspection reports, other reports and research. There will be need for a dialogue in many cases between local safeguarding partners and the National Panel to support decision making. Information should be shared with the panel on request.

The panel should inform the relevant safeguarding partners **promptly** if they consider:

- Further information is required before a decision can be made by the National Panel.
- A national review is appropriate, setting out rationale for decision making (including to families) and next steps.

The panel will inform the Secretary of State when a decision is made to carry out a national review.

The panel will discuss with the local partnership the potential scope and methodology of the review and how they will engage with them throughout.

There will be instances where a local review has been carried out that is relevant to a national review or a local review has not been carried out, but the panel feel that such a review would be helpful to a national review sometime in the future. In these circumstances the panel will engage with the local partnership to agree conduct of reviews

Links to Other processes that may affect CSPRs

There may be a criminal investigation, a coroner's investigation and/or professional body disciplinary procedures running alongside a local or national review. The panel and local safeguarding partners will agree a clear process of how they will work with other processes including Domestic Homicide Reviews or Safeguarding Adult Reviews.

When running a CSPR all relevant areas that need to be addressed should be established at the outset to reduce potential for duplication for families and staff.

Any CSPR will need to take account of a coronial enquiry and/or any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process.

Coroners

Coroners are independent judicial office holders who are responsible for investigating violent, unnatural deaths or deaths of unknown cause and deaths in custody, or otherwise in state detention, which are reported to them. The Coroner may have specific questions arising from the death of a child/and or adult at risk. These are likely to fall within one of the following categories:

- Where there is an obvious and serious failing by one or more organisations.
- Where there are no obvious failings, but the actions taken by organisations require further exploration/explanation.
- Where a death has occurred and there are concerns for others in the same household or other setting (such as a care home).
- The Coroner or his or her officers identify deaths that fall outside the requirement to hold an inquest but follow-up enquiries/actions.

In the above situations, the SSCP/ASB should consider instigating a CSPR.

Please note: Any correspondence with the Coroner must go through Stockport Council Legal Department.

Police Investigations

Where a learning review is taken forward and there are ongoing police processes it is important that information is shared in a timely fashion. This includes if the review has concluded and new information is uncovered in ongoing police investigations. In such instances, Police partners should ensure information is shared via normal MASSH pathways for operational purposes and into the PIP for consideration of any learning impacts.

Complaints & Escalation Procedure

Where a professional is unsatisfied with decisions or processes in relation to reviews then they should utilise the Greater Manchester Escalation process which can be accessed via the Greater Manchester Safeguarding Procedures; https://greatermanchesterscb.proceduresonline.com/chapters/p_resolv_prof_dis.html?zoom_highlight=escalation

Where a complaint is received from a member of the public, about a decision or review of the SSCP this will initially be responded to by the Safeguarding Children's Partnership Manager in consultation with the relevant Head of Service, with a written response within 28 days of receipt.

If the complainant is unsatisfied with the response, they should contact the Partnership Manager who will arrange for their complaint to be considered by the most appropriate person. For example, if it is about decisions by partner agencies then the Independent Chair may be asked to mediate the concerns.

All written complaint responses will include details of how to contact the Local Government Ombudsman.

The Safeguarding Children's Partnership Manager will ensure that a record is kept of complaints received, responded to and those referred to partner agencies. Complaints and copies of responses will be securely retained in accordance with the principles of data protection legislation and the SSCP retention policy.

Appendix A: Case Notification Form

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This referral form is used to notify Stockport Safeguarding Children Partnership that there may be a case in need of some form of Partnership response. This could be a **Rapid Review, A Local Practice Learning Review or a Case Escalation.**

A Rapid Review will be appropriate where the case meets notifiable incident criteria and you believe that the 3 Statutory Partners need to assess the case for a Child Safeguarding Practice Review and report this to the National Panel for consideration of a national review.

A Local Practice Learning Review is for cases that are not notifiable incidents but where professionals feel there may be learning about how we can improve our local multi-agency working through some form of multi-agency learning process or event. This may also be cases where you believe the practice has been very good and may show case effective multi-agency working.

Case Escalation is for cases that there has been professional disagreement about the response and the professionals involved, and their managers, have been unable to find a resolution. Therefore, the three statutory partners and potentially the independent Chair may need review decision making and undertake mediation.

Professionals should discuss the case with their agency designated safeguarding lead or the Stockport Safeguarding Children's Partnership manager to determine which learning and support process is required before submitting the form. This will support the partnership team in determining the most appropriate response pathway.

This referral template consists of the following colour coded section:

Section 1: Referral	**To be completed by referring agency**
Section 2: Outcome and Recommendations	**To be completed by the Practice Review Virtual Panel and SSCP Partnership Manager**

There is further guidance at the end of the form in "Tips for Referrers"
Forms should be returned via email to: lsb@stockport.gov.uk

SECTION 1: REFERRAL DETAILS	
1.1 Referrer Information	
Date of Referral to SSCP	
Date of event prompting referral	
Referring agency	
Name of referrer	
Job title	
Contact details (telephone and email)	
Who has the referral been discussed with (include managers details and any external agency discussions)	
Your agencies nominated lead for the potential review process	Name:
	Role:
	Contact email / number:

1.2 Reason for notification *(please tick √ the box that applies for the pathway you are seeking)*		
A	**Referring a Notifiable Incident that requires a Rapid Review Screening panel to determine if it is a Serious Child Safeguarding case**	

Please note a Serious Child Safeguarding Case is defined by the Working Together 2018 as:

10. Serious child safeguarding cases are those in which:

- *abuse or neglect of a child is known or suspected and*
- *the child has died or been seriously harmed*

11. 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 should also cover 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.

This includes cases of abuse or neglect leading to serious harm both within and outside of the local area.

Notifiable Incidents also include any Looked After Child even if abuse or neglect is not known or suspected. Areas can also have regard to incidents within institutional regulated settings such as child minders, children's homes secure homes and adoption support agencies.

Local Authorities have a duty to notify these cases to the Secretary of state and Ofsted via the National Panel. Cases meeting the threshold for a Rapid Review screening that is reportable to the National Panel should be those that are distinct from usual Child Protection cases in terms of issues in relation to multi-agency working and the harm experienced. Reviews use the concept of serious harm to encourage professionals to differentiate between cases of significant harm that are child protection and those that are so serious they require the addition of a multi-agency review process.		
B	**Referring a case for consideration of a local practice review**	
These are cases that do not meet the notifiable incident criteria but are felt to hold valuable lessons for practice. For example, these may be cases that have uncommon complex issues where professionals may have struggled to effectively manage risk or work collaboratively to address concerns. This could be cases of criminal exploitation or Female Genital Mutilation. The purpose of referring these cases is to create a learning opportunity for the professionals involved to reflect on what worked well, what caused some concerns and identify what could be done to improve experiences and outcomes moving forward. Similarly, this referral could be to share a good practice case where professionals were able to effectively collaborate and coordinate practice to the benefit of the child / young person or family. In these instances you may be seeking to show case a method of working that celebrates effective partnership.		
C	**Escalating a dispute case for Partnership Review**	
Professionals should be able to challenge each other in order for practice to be effective. However, there are occasions where challenge and disagreements can become detrimental to multi-agency working and impede effective outcomes for the child and/or young person. In these cases professionals have, in conjunction with their line managers, been unable to reach a consensus on how best to work together. This may relate to the threshold a case should be managed at or the interventions required or the specific response of an agency. Before the partnership can become involved professionals must have attempted to discuss and resolve the dispute amongst themselves. If no way forward has been found and a decision urgently needs to be reviewed and challenged then professionals can escalate the matter to the SSCP Partnership Manager. The case will then be discussed by the statutory partners and reviewed with the Independent Chair for a final determination.		

1.3 CHILD DETAILS	
Date of Birth	
Age	
Gender	
Disability	

1.4 Interested Parties: Personal i.e. parents, siblings etc.				
Relationship to child	**Name**	**Date of Birth**	**Address**	**Informed of referral? Y/N**
Please identify how the parent/ carer and/ or child and young person may be involved in any learning process taken forward. If there are reasons you believe they may not be able to participate please state the rationale. If they are already aware of the potential process, please state how they would like to be part of the potential case review:				

1.4A Interested Parties: Professionals i.e. agencies involved in supporting the child or family			
Agency	**Name of professional /key-worker**	**Contact Details (email or phone)**	**Nature of involvement and/or intervention**

1.5 SUMMARY OF EVENTS AND IMPACT ON THE CHILD					
Characteristics of Case *(please tick any that apply)*					
Domestic abuse		Alcohol abuse		Drug abuse	
Parental mental health		Fabricated illness		Shaken baby syndrome	
CSE / Sexual abuse		Parent in care / care leaver		Missing	
Child of teenage parent		Gun and Gangs		Serious illness	
Emotional abuse		Recent neglect		Long standing neglect	
Physical abuse		Self-Harm / Suicide		Accidental Injury	
Other features (please specify)					
ABOUT THE INCIDENT **Brief description of the event triggering the referral, including key dates. Why is this case being referred at this time? Including details of any immediate action taken to ensure child/siblings safety:**					

WHY YOU ARE MAKING THIS REFERRAL: YOUR VIEWS **Please explain why you think this meets the criteria for the process you selected above in section 1.2, use the prompts below to structure your explanation.**
What worked well: What didn't work well: What do you think are some of the key issues and what you think needs looking at in the review:

SECTION 2: TO BE COMPLETED BY THE SSCP Virtual Panel				
Names and organisation of Panel Members making decision:				
SMBC:	**GMP:**	**CCG:**	**Other:**	
2.1 Referral Decision of Virtual Panel (tick √ one)				
Meets threshold for Rapid Review	**Meets threshold for a case practice review, but not a Rapid Review**	**Meets criteria for Escalation**	**Does not require SSCP response (i.e. alternative process more appropriate SAR / DHR)**	**Queries back to referrer before decision can be made**
2.2 Rationale for the Decision				
Please refer to Virtual Panel Guidance (Appendix 3) **Please indicate why the panel has determined the chosen pathway for this case.** **In cases where a Rapid Review is selected please note how the Serious Harm criteria has been determined**				
Selected Pathway				
Rationale				

2.2 Identified Leads to coordinate review process from individual agencies involved			
Name	**Role**	**Organisation**	**Contact Details**

Top Tips for Referrers

Documents that may help you:

- Practice Review Policy
- Children and Families in Practice Reviews – Guidance

Any agency can refer a case to the Practice Improvement Partnership (PIP) requesting that consideration be given to holding a Learning Together Review if they identify a case where they believe that the criteria for review are met.

Single Agency agreement: Where an agency has identified a possible review referral, the case should first be considered internally within the organisation at the appropriate level. But with due consideration to timescales. Using the guidance available (such as the Practice Review Policy and Thresholds, consider the rational for making a referral and be clear why you think it meets criteria. For some cases, such as child deaths, it will be obvious that referral is required. Each organisation needs to decide how a referral will be verified internally before the referral is made to Stockport Safeguarding Children Partnership. This process should be clearly communicated and noted in the child record within that agency.

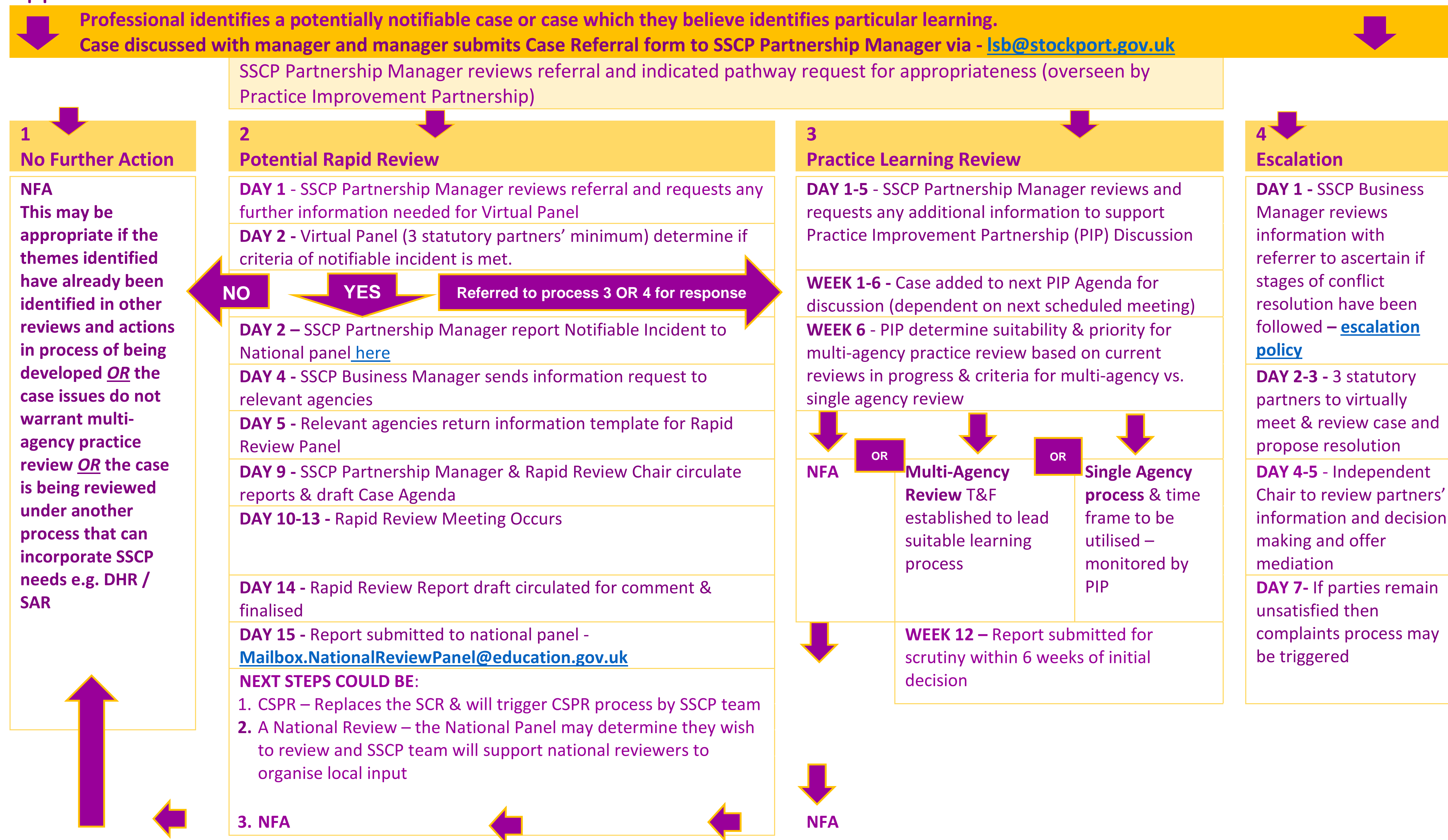
1. Consult key worker: There is an expectation that the referrer would have a conversation with any allocated social worker or other key worker to alert them to the intention to refer and gather their views. Be clear that the right way to progress is through referral, and not the Escalation Policy.

2. Discuss with child / family as appropriate: It is good practice to involve parents and children (subject to age and understanding) in a meaningful way, and reviews should where appropriate be informed by family members' knowledge and experiences relevant to the period under review. Please provide your views on how children and their families should be involved, and who should be responsible for facilitating their involvement, recognising that not all information should be shared with the child or family.

   The overarching principle should always be to act in the best interests of the child. If it is decided that such involvement is not in the best interests of the child, then the reasons for the decision should be clearly stated in the referral.

3. Completing the form: Please complete section 1 only. Whilst we recognise the referrer may not know all the information, please provide as much information that is known at the time of the referral. If information is not available, please do not delay in sending notification, as this information can be submitted at a later stage.

Appendix B: Process Overview



Safeguarding Children in Stockport

Appendix C: Virtual Panel Guidance

The Virtual Panel Process Guidance	
What is the purpose of Virtual panel?	Stockport Safeguarding Children Partnership has developed a core virtual panel for the purpose of swiftly reviewing case referrals that are requesting a Rapid Review.
What does the Panel do?	A number of referrals are received by the partnership, but it needs to be determined whether or not the specific criteria for a Rapid Review is met or whether other partnership or single agency learning processes may be more appropriate e.g. an action learning circle or case escalation process or 72 Hour Incident review.
Who is the Panel?	The three core statutory partners nominate senior leaders to undertake this process – Local Authority, Police and CCG
What do they do?	Panel members are required to: 1. Review the referral form 2. Identify if their own agency system holds further information to inform their decision making 3. Discuss (virtually via skype or email or telephone call) with the panel views on whether or not Serious Harm Criteria is met and the case is determined as Notifiable and so warrants a Rapid Review Panel to explore criteria further 4. Ensure a clear rationale for the decision is documented and shared to the SSCP Business manager 5. Ensure that any further processes are agreed i.e. commence a Rapid Review / Request PIP to take forward a learning process / Case Escalation / No Further Action / Single Agency process
When would a review be needed?	**A Rapid Review** will be appropriate where the case meets notifiable incident criteria and you believe that the Partnership needs to assess the case for a Child Safeguarding Practice Review and report this to the National Panel for consideration of a local OR national review.
What is the criteria used?	**The criteria for a review are defined by Working Together 2018 as:** SSCP must identify serious child safeguarding cases to ascertain if guidance indicates the need for a review.

	Serious child cases are defined as distinct from usual Child Protection cases by the category of serious harm in a case where abuse or neglect is known or suspected ***Serious Harm is defined as*** *serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover 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.* Panel members should reflect on how the case referred is distinct from other Child Protection cases as a result of the level of harm being seen. If these criteria is identified then the Rapid Review Panel will consider the wider criteria to propose what, if any, learning process is appropriate and required. As Looked After Children are in the care of the local authority their deaths must always be notified to the National Panel by the Local Authority. Where a child dies or is seriously harmed outside of England are also cases that should be considered for notification and potentially review.

Prompts for Consideration

1. Not all cases of child protection warrant a review so consider what factors are evident that make this case distinct from cases within the child protection arena i.e. problematic practice of professionals linked to harm caused that is beyond individual practitioner decision making and so indicates problems in the wider system of practice.
2. Remember that the purpose of a review is to prevent similar occurrences by identifying lessons for the way we all work together and the system – matters of problematic individual practice not in line with procedure are for other processes such as disciplinary action or regulatory body referrals
3. A review is not an investigation – there are criminal investigation processes to assess culpability and crimes.
4. Reflect on learning and review processes already in place for individual agencies and whether these either are sufficient to address the case or should take place before a wider multi-agency review is determined i.e. mental health death reviews, incident reviews etc.
5. The specific criteria on page 84 of Working Together 2018, will be unpicked in the rapid review meeting when more information is collected. The focus at virtual decision stage is on whether this review process needs to be triggered.

6. Working Together 2018 does state that meeting of criteria does not mean that reviews must be carried out – partners can consider the appropriateness of a child safeguarding practice review. For example, if a case has been triggered with similar learning and process issues it may not be justifiable to duplicate.
7. Don't forget that focus can also be drawn to positive practice – if there is good practice identified a proposal can be made to PIP to consider a good practice review.

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Appendix D: Rapid Review Information Request Form

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IMPORTANT GUIDANCE INFORMATION **Please complete this form as described below.**
Each agency representative is to complete this form to summarise information available within their agency. Each representative should complete fully those sections for which they have information. If your agency does not hold the required information, please indicate this in Section A and return the form. The information provided will be discussed at the Rapid Review Panel meeting. This information is required whenever there is notification of a serious incident or referral for a practice review. This information provides some basic facts about the case that supports a panel to determine whether or not the referral needs to progress to a child safeguarding practice review. The purpose of these processes is outlined in Working Together 2018 as: *"When a child suffers a serious injury or death as a result of child neglect, understanding not only what happened but also why things happened as they did can help to improve out response in the future. Understanding the impact that the actions of different organisations and agencies had on the child's life, and on the lives of their family, and whether or not different approaches or actions may have resulted in a different outcome, is essential to improve our collective knowledge. It is in this way that we can make good judgements about what might need to change at a local or national level."* The information you provide will support the area to identify any lessons that can be learnt. When completing this form please give regard to: 1. Any and all relevant and significant events from your history of involvement 2. Reflect on how these events may have impacted on the child, young person, family and your own practice to present analysis of your agency's involvement 3. Please consider if there is information or events outside of the period under review which give context and greater understanding and provide any relevant information in relation to them 4. Please provide a chronology that summarises contact around significant events – it is not necessary at this stage to list all non-significant agency contact, this should be summarised for the panel 5. Please note we have 15 working days from notification to conclude the rapid review and submit a report – please return your information promptly to enable this timescale to be met 6. Please give consideration of the need to secure files if a local or national review is selected

A. Identifying and Reporting Details

Name of Child or Young Person		**Date of Birth**		
Date of death / critical incident		**Gender**	Female	☐
			Male	☐
Current location of child				

Agency Report Provided by

Agency		**Name of Author**	
Role		**Date Submitted**	
Address			
Tel No		**Email**	
Name of Practitioners involved:		**Contact Details of Practitioners involved:**	

Has your agency had any contact with the child, family or close associate as listed in the referral form? (delete as appropriate)	**Yes /No**
Name of Senior Agency manager that has Quality Assured the Report:	

B. Other Significant Family & Household Members

Full Name	DOB	Relationship	Full Address

C. The Child

Ethnic group	☐	White	☒ White British ☐ White Irish

			☐ Any other White background
	☐	Mixed	☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Any other mixed background
	☐	Asian or Asian British	☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Any other Asian background
	☐	Black or Black British	☐ Caribbean ☐ African ☐ Any other Black background
	☐	Chinese or other ethnic group	☐ Chinese ☐ Any other ethnic group
	☐	**Not known by Agency / not stated**	
Religion (please state)			
	☐ **Not known by Agency**		

D. Summary of Event.

Type of Incident:	**Death** ☒		**Critical Incident** ☐
Summary of Event:			

E. Summary of Agency Involvement

Please provide a brief summary of the nature of your involvement below to sit alongside your agency chronology of significant events requested at **Appendix A**

F. Assessment of Factors that may have influenced the event.

Please provide information relating to:

- Developmental Issues – including behaviour, education and health

- Parental Capacity – including provision of care, substance misuse, mental health, domestic abuse and attachment issues
- Family & Environment – including housing, wider family support, employment & income and diversity
- Multi-Agency working – including how agencies worked together and any barriers to this

G. Agency Actions Identified

Include any key actions identified from your review of your agency's involvement in the case i.e. policy or procedure change for the agency

H. Issues for discussion at the Case Review Panel

Include any learning that you think needs to come out of the review, including:

- Issues for process and practice
- Issues for multi-agency working
- Consider what worked well, what worked less well, anything you were concerned about etc.

I. Views of the Child, Young Person and / or their Family
Please provide any information that your agency holds in relation to the child's views, wishes or feelings? Or their family.

J. Any other Information
Please record anything here that you have not referenced above or in your chronology in Appendix A that you believe relevant to the panels' consideration of the case.

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Appendix: Single Agency Chronology of Significant Events

Please complete the document below to capture your contact and any significant events you are aware of.

Agency	Involvement with	Date from	Date to	Description of significant event/activity and outcome of event	Child Seen? Y/N	Review and analysis
Enter name of agency in all rows to enable cut and paste to a combined chronology	*Subject of event, e.g. Child, Mother*	*dd/mm/yyyy hh:mm*	*dd/mm/yyyy hh:mm*	*Details of key event and any observation*	*Y/N-if Y, Please State initials of children seen*	*Identify what went well, worried about. Include where statutory requirements not met.*

Safeguarding Children in Stockport

Appendix E: Rapid Review Panel Agenda

<table>
<tr><td>1</td><td colspan="2">Welcome, Purpose & Introductions</td><td>Chair</td></tr>
<tr><td colspan="4">Please remember that the panel has been called as the Virtual Panel has determined the criteria of serious harm has been indicated and a case determined as “Notifiable”.
Therefore, members will be considering the decision guidance below to consider whether there are improvements in safeguarding, relevant local learning and/or understand any systemic issues.
The panel do not have to take forward a review if criteria below is indicated but there must be a clear rationale of the decision made</td></tr>
<tr><td>2</td><td>Overview of the case</td><td>Summary by Chair from submitted reports</td><td>Chair</td></tr>
<tr><td>3</td><td>Discussion with invited Partners</td><td>Opportunity for questions, discussion & clarification</td><td>All</td></tr>
<tr><td>4</td><td colspan="2">Assessment of Need by Core Panel</td><td>Core</td></tr>
<tr><td colspan="4">Questions to be considered:
• What potential improvements may be needed to safeguard and promote the welfare of children? i.e. were there gaps in responses due to lack of training / understanding or service? Were there any issues in local processes or policy? Or was this an extraordinary incident that could not have been predicted or planned for?
• What evidence was there that the case highlights recurrent themes in the safeguarding and promotion of the welfare of children? i.e. have these issues been identified before? Has action been taken and is this evidence of a lack of impact? Are these concerns already known and actions not yet implemented?
• Were there concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children? Or the notable absence of agency involvement? i.e. were there challenges in agencies working collaboratively to address the needs of the child / family? Were there gaps in information sharing? Were these issues so serious and endemic they raise concerns for local practice? Was the family / child / young person invisible to services when they should have been clearly identified as needing support?
• Are we being asked to consider a review by the Child Safeguarding Practice Review Panel who have considered and concluded a local review may be more appropriate? i.e. the case has been previously reviewed and notified as not for a review, but we have been challenged by the panel?
• Are the panel concerned about the actions of a single agency? i.e. there are significant failures to act that raise concerns about safeguarding decision making. Are there other processes that should have happened and don’t appear not be in place e.g. 72 Hour Incident review? Mental Health Death review?
• Is more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around? i.e. do there appear to be challenges with working across borders in terms of accessing services and developing a collaborative support approach?
• Does the case raise issues relating to safeguarding or promoting the welfare of children in institutional settings (i.e. child minders homes / adoption services / residential placements / secure homes etc.)? i.e. has there been a death in a secure children’s home or mental health secure setting? Are there processes to provide scrutiny and assurance</td></tr>
</table>

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	around this incident? Do partners have concerns regarding how the incident has happened or the settings ability to manage such cases?	
5	Conclusion & Proposal to National Panel	Chair
6	Actions	All

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Appendix F: RRP Chair Agenda Notes

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1	Welcome & Introductions	
1.1	**Attendees**	
	[Insert list]	
1.2	**Purpose of the Meeting**	
	The purpose of a Rapid Review is defined by Working Together 2018 as: *3. …to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally... 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.* *4. Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account…* *7. Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area.* *17. Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review… Decisions on whether to undertake reviews should be made transparently and the rationale communicated appropriately, including to families.* *18. Safeguarding partners must consider the criteria and guidance below when determining whether to carry out a local child safeguarding practice review on a 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 which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate* They can also give regard to: • *where the safeguarding partners have cause for concern about the actions of a single agency* • *where there has been no agency involvement and this gives the safeguarding partners cause for concern*	

	• *where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around* • *where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings (i.e. child minders homes / adoption services / residential placements / secure homes etc.)*	
2	**Overview of the case**	
2.1	[Insert brief summary of the case from the referral & any key points raised within the returned reports requested. This summary should prevent the need for members to read reports out and focus time on discussing relevant points pertinent to determining if a Child Safeguarding Practice Review is needed]	
3	**Discussion with invited Partners**	
3.1	[Record key questions and discussion points from the interaction with wider partners to clarify the nature of the case]	
4	**Assessment of Need by Core Panel**	
Capture the areas of potential focus against review criteria outlined below with prompts for discussion		
4.1	***What potential improvements may be needed to safeguard and promote the welfare of children****? i.e. were there gaps in responses due to lack of training / understanding or service? Were there any issues in local processes or policy? Or was this an extraordinary incident that could not have been predicted or planned for?*	
	[notes & views]	
4.2	***What evidence was there that the case highlights recurrent themes in the safeguarding and promotion of the welfare of children?*** *i.e. have these issues been identified before? Has action been taken and is this evidence of a lack of impact? Are these concerns already known and actions not yet implemented?*	
	[notes & views]	
4.3	***Were there concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children? Or the notable absence of agency involvement?*** *i.e. were there challenges in agencies working collaboratively to address the needs of the child / family? Were there gaps in information sharing? Were these issues so serious and endemic they raise concerns for local practice? Were the family / child / young person invisible to services when they should have been clearly identified as needing support?*	
	[notes & views]	
4.4	***Are we being asked to consider a review by the Child Safeguarding Practice Review Panel who have considered and concluded a local review may be more appropriate?*** *i.e. the case has been previously reviewed and notified as not for a review but we have been challenged by the panel?*	
	[notes & views]	
4.5	**Are the panel concerned about the actions of a single agency?** i.e. there are significant failures to act that raise concerns about safeguarding decision making? Are there other processes that should have happened and don't appear not be in place e.g. 72 Hour Incident review? Mental Health Death	

	review? Is there an agency absent from the case that should have been involved?	
	[notes & views]	
4.6	**Are more than one local authority, police area or clinical commissioning group involved, including in cases where families have moved around?** i.e. do there appear to be challenges with working across borders in terms of accessing services and developing a collaborative support approach?	
	[notes & views]	
4.7	**Does the case raise issues relating to safeguarding or promoting the welfare of children in institutional settings (i.e. child minders homes / adoption services / residential placements / secure homes etc.)?** i.e. has there been a death in a secure children's home or mental health secure setting? Are there processes to provide scrutiny and assurance around this incident? Do partners have concerns regarding how the incident has happened or the settings ability to manage such cases?	
	[notes & views]	
5	**Conclusion & Proposal to panel**	
5.1	**The conclusion of the panel is that…..(insert whether or not review is proposed locally or nationally)**	
	The reasons a review is/ is not proposed is….. [insert rationale for needing review and areas for focus from criteria above, include why this might be a nationally relevant case or not]	
6	**Actions**	
	[Identify what actions may be required including a review or if not indicated any learning actions such as promoting a lesson learnt from the discussion to a specific agency or sector.]	