Serious Child Safeguarding Incident and Child Safeguarding Practice Review Procedures and Practice Guidance

May 2021

Version Control

Title	**Serious Child Safeguarding Incident and Child Safeguarding Review Procedures and Practice Guidance**
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Update and Approval Process			
Version	**Group/Person**	**Date**	**Comments**
DSP1	Updated by Business Unit	July 2019	Rebranded and updated to reflect new safeguarding partnership arrangements in line with Working Together to Safeguard Children 2018.
DSP1.1	Statutory Safeguarding Partners (SSP)	July 2019	Updated to reflect Updated to reflect decision by SSP that governance of reviews sits with the Learning and Development sub group. Approval of final report rests with the SSP.
DSP 1.2.1	Learning and Development sub group	March 2020	Update from L & D subgroup to tighten up decision making following challenge to SSP on outcome of serious incident referrals.
DSP 1.3, 1.3.1 & 1.4	Learning and Development sub group	February 2021 – May 2021	Updates from L&D to reflect changes in SAR procedures and formatting and Merging of Serious Child Safeguarding incident procedure into one document to simplify/reduce duplication – shared for consultation and sign off 30 April 2021.

Issue Date	May 2021
Review Date	May 2023 or sooner if legislation/practice changes

Contents

1. INTRODUCTION

1.1 For the purpose of this document, the term Statutory Safeguarding Partners refers to the new statutory arrangements outlined in Working Together to Safeguard Children 2018. The responsibility for Safeguarding arrangements rests with the Statutory Safeguarding Partners and for Darlington they are:

- Darlington Borough Council
- Tees Valley Clinical Commissioning Group
- Durham Constabulary

1.2 Child Protection in England is a complex multi-agency system with many different organisations and individuals playing a part. Sometimes a child suffers a serious injury or death as a result of child abuse or neglect. Understanding not only what happened but also why things happened as they did, can help to improve responses 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 his or her family, and whether or not different approaches or actions may have resulted in a different outcome, is essential to improve our collective knowledge.

1.3 This guidance has been developed to enable organisations to be clear on their responsibilities, the process for dealing with serious child safeguarding incidents and how to learn from experience and improve services. This includes the duty to conduct Child Safeguarding Practice Reviews, which are local reviews to examine the way agencies and individuals which have been involved with a child/ren have acted, when abuse or neglect are suspected or known. The purpose of a Child Safeguarding Practice Review is to identify learning that will bring about improvements, so that the likelihood of harm to children is minimised.

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

1.5 This guidance specifies the statutory requirements and the working arrangements in respect of serious child safeguarding incidents, Child Safeguarding Practice Reviews and alternative learning reviews, including the interface with other reviews such as Safeguarding Adult Reviews (SAR) and Domestic Homicide Reviews (DHR).

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

- **The Child Safeguarding Practice Review Panel (CSPRP);** this is the national panel appointed by the Secretary of State for Education which considers all notifications of serious incidents. The Local Authority has a duty to notify the CSPRP of any serious child safeguarding incident in their area within five days of the receipt of a notification.
- **The Rapid Review Panel;** this is the local panel which meets within fifteen days of a notification to the Child Safeguarding Practice Review Panel, to consider the circumstances of a notifiable (serious) incident and to inform Statutory Safeguarding Partners of the Rapid Review decision.

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

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

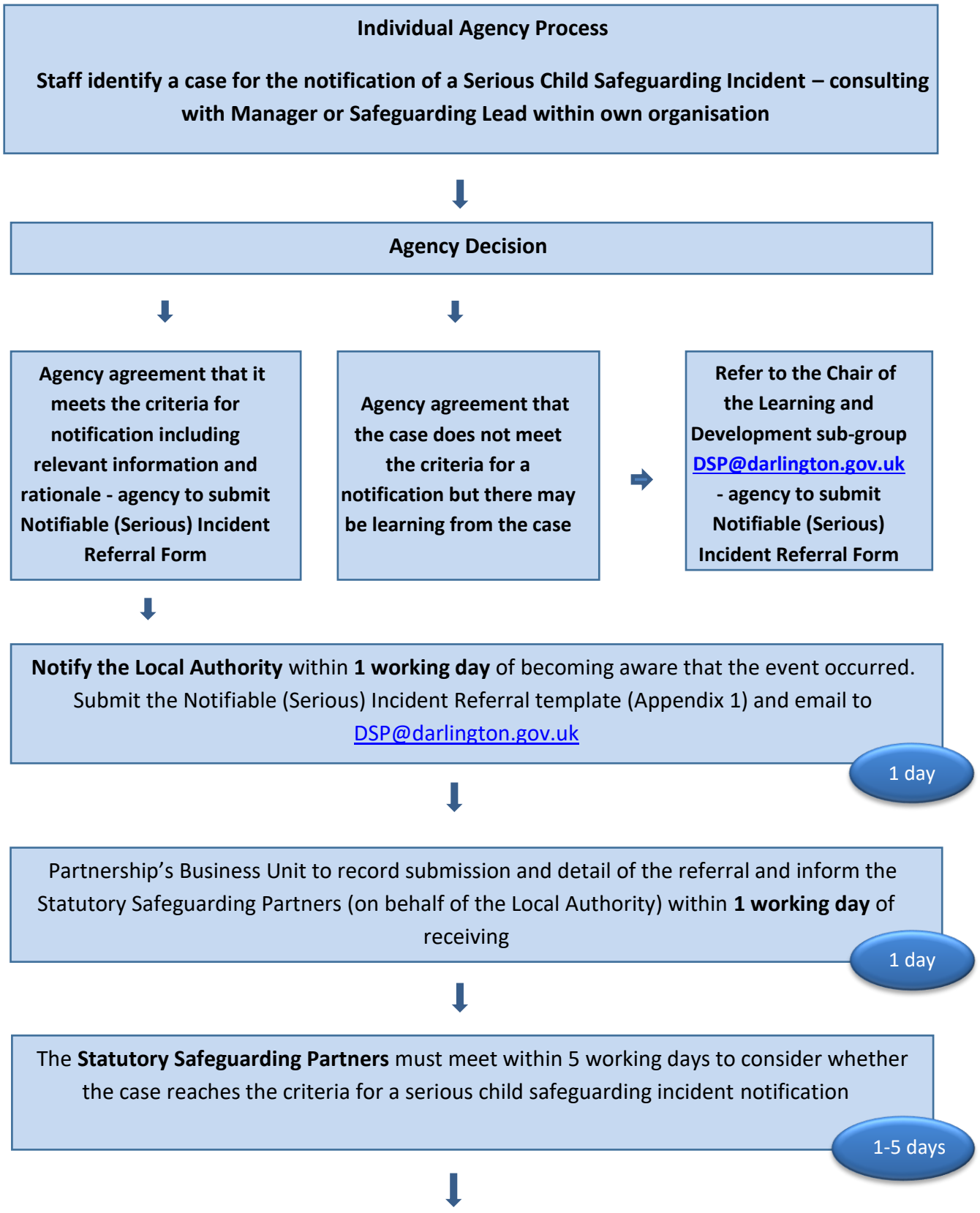
a) the child dies or is seriously harmed in the local authority's area, or
b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

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

'Serious harm' is defined in Working Together to Safeguard Children 2018 as including (but not limited to), serious and/or long-term impairment of a child's mental health or intellectual, emotional, social, or behavioural development. It also covers impairment of physical health. This is not an exhaustive list and when making decisions, judgement should be exercised in cases where impairment is likely to be long term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.

3. PROCESS MAP OUTLINING THE PROCEDURES AND TIMESCALES

This flowchart summarises the process and timescales when considering whether a Serious Child Safeguarding Incident reaches the threshold for notification to the Child Safeguarding Practice Review Panel and the procedure which must be followed:



If the Statutory Safeguarding Partners agree the case reaches the criteria for serious child safeguarding incident notification, the Local Authority has a duty to notify the Child Safeguarding Practice Review Panel/Ofsted/DfE no later than **5 working days of** becoming aware that the event occurred

5 days

If the criteria are met, the **Statutory Safeguarding Partners** will convene a **Rapid Review Panel** within **7-10 working days** of acknowledgement from the Child Safeguarding Practice Review Panel

7-10 days

The **Statutory Safeguarding Partners** will inform the **Child Safeguarding Practice Review Panel** of their decision whether a Child Safeguarding Practice Review or national review is appropriate within **15 working days.**

15 days

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

If decision is made to undertake a Child Safeguarding Practice Review it should be completed within **6 months** of date of decision to hold

6 months

4. INITIATING A CHILD SAFEGUARDING PRACTICE REVIEW - THE REFERRAL PROCESS

4.1 When a serious child safeguarding incident occurs, the first step for any organisation is to take appropriate action to ensure the immediate safety of the child/ren or minimise the impact of any serious harm (refer to the Darlington Safeguarding Partnership Child Protection Procedures).

4.2 Any agency or individual (including a member of the public) can refer a case for consideration of whether it meets the criteria for a CSPR or other review if there is learning to be explored.

4.3 If an individual within an agency considers that the criteria for notification or other review are reached, in all circumstances they should discuss this with their line manager or Safeguarding Lead in the first instance before submitting a notification and follow internal processes.

4.4 Managers and Safeguarding Leads should be aware of the criteria for the submission of a notification of a Serious Child Safeguarding Incident. A decision made as to whether a notification should be submitted, and agencies to ensure there is enough information to support the decision for a notification. You may find it helpful to discuss the concern with your agency representative on the Safeguarding Partnership, or the Safeguarding Partnership's Business Manager (DSP@darlington.gov.uk).

4.5 Where any individual or agency believes or suspects there may have been circumstances where the criteria for a notification have been met, the case **must** be referred to the Safeguarding Partnership's Business Unit. A referral is made by submitting the **Notifiable (Serious) Incident Referral Form** (Appendix 1) to the Safeguarding Partnership's Business Unit DSP@darlington.gov.uk. The referral form should be submitted within **1 working day**. You should ensure your manager is aware of the submission of the referral.

4.6 The Safeguarding Partnership's Business Manager will record the information and inform the Statutory Safeguarding Partners within **1 working day**. The Statutory Safeguarding Partners/Independent Scrutineer/Chair will meet within **5 working days** of receipt of the notification to consider the case.

4.7 If an agency agrees that the case does not meet the criteria for Notification, however highlights there may be learning to explore, the **Notifiable (Serious) Incident Referral Form** *(Appendix 1)* should be completed with relevant information and forwarded to the Safeguarding Partnership's Business Unit DSP@darlington.gov.uk.

5. RESPONSIBILITY OF THE LOCAL AUTHORITY TO INFORM STATUTORY PARTNERS AND CHILD SAFEGUARDING PRACTICE REVIEW PANEL – DECISION MAKING

5.1 The Local Authority is required to report a serious child safeguarding incident to the Statutory Safeguarding Partners within **1 working day** of becoming aware that the event has occurred (the Business Unit may do this on behalf of the Local Authority). The Statutory Safeguarding Partners will determine whether the event reaches the criteria for a notification to the Child Safeguarding Practice Review Panel, Ofsted and the Secretary of State for Education (DfE).

5.2 If the Statutory Safeguarding Partners agree that the criteria has been reached for a serious child safeguarding incident notification, the Local Authority has a statutory duty under Working Together to Safeguard Children 2018, to refer all serious child safeguarding incidents to the Child Safeguarding Practice Review Panel within **5 working days** of becoming aware that the event has occurred, using the online child safeguarding incident notification system.

5.3 Online notifications to the Child Safeguarding Practice Review Panel will also be shared with Ofsted (to inform its inspection and regulatory activity) and with DfE to enable it to carry out its functions. The Local Authority must also notify the Secretary of State for Education (DfE) and Ofsted where a child looked after has died, whether or not abuse or neglect is known or suspected.

5.4 If the Statutory Safeguarding Partners determine that a case meets the criteria for a serious child safeguarding incident, a Rapid Review Panel should be convened (see section 6 below).

5.5 If the Statutory Safeguarding Partners determine that a case does not meet the criteria for a Serious Child Safeguarding Incident notification, the SSP should consider whether there may nevertheless be the potential for single or multi-agency learning (which falls below the threshold required for a Child Safeguarding Practice Review), or whether practice issues have been highlighted. In these circumstances, the Statutory Safeguarding Partners should refer the case to the Learning and Development sub-group Chair, who will determine whether there should be a multi-agency practice review or a single agency review of the case (Referral form - Appendix 2). This process will be supported and monitored by the Learning and Development sub-group.

5.6 If the Statutory Safeguarding Partners determine that a case does not meet the criteria for a Serious Child Safeguarding Incident, and there are no single or multi-agency practice issues to be considered, no further action will be taken. Whatever the decision of the Statutory Safeguarding Partners, the rationale will be recorded and shared with the Learning and Development sub-group.

5.7 It is expected that the Local Authority will feedback to the referrer the outcome of the notification within 5 working days of the decision being made. If the referrer is dissatisfied with this outcome, the matter should be discussed with the Director of Children and Adult Services and/or the Statutory Safeguarding Partners.

6. THE RAPID REVIEW PANEL

6.1 When the Statutory Safeguarding Partners have determined that a case meets the criteria for a serious child safeguarding incident notification, a Rapid Review Panel meeting should be convened. See guidance in Working Together to Safeguard Children 2018. The Statutory Safeguarding Partners must make arrangements to:

- identify serious child safeguarding cases which raise issues of importance in relation to the area and
- commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken

6.2 The Rapid Review Panel should be convened **within 15 working days** of the acknowledgement of the receipt of the notification from the Child Safeguarding Practice Review Panel, however every effort will be made for a meeting to take place within **7-10 working days** to consider the information. This is to allow sufficient time to report the decision to the Child Safeguarding Practice Review Panel within the required timescales (15 working days).

6.3 Meeting the criteria does not mean that Statutory Safeguarding Partners must automatically carry out a Child Safeguarding Practice Review. The purpose of the Rapid Review Panel is to decide whether the serious child safeguarding incident reaches the threshold for a local Child Safeguarding Practice Review (CSPR), or whether it may be appropriate for a National Review

6.4 The Rapid Review Panel meeting will be chaired by a representative(s) of the Statutory Safeguarding Partners and will be attended by strategic members of the Multi-Agency Safeguarding Partnership Group and/or Learning and Development sub group, supplemented by additional practitioners with the necessary knowledge or expertise pertinent to the circumstances of the case. The Rapid Review Panel may also wish to have available specialist advisers, whose role will be to advise panel members during the process.

6.5 The Rapid Review Panel meeting will have the expertise required to make the recommendation to the Statutory Safeguarding Partners. The Rapid Review Panel will be provided with information/reports from the key agencies involved, which will inform the decision making as to whether the criteria are met. This information includes the nature of agency involvement with the child(ren)/family, any safeguarding issues of which the agency was aware during the involvement, and what information the agency holds in respect of the incident. For the purposes of the Rapid Review Panel, the Statutory Safeguarding Partners will request information dating back no more than 3 years. However, if agencies believe there is relevant information outside of this timescale, this information should be shared at the meeting. It is important for the panel to have sufficient information before discussion begins. However, the Rapid Review Panel is **not investigating** the circumstances of the incident and is **not conducting** the Child Safeguarding Practice Review (CSPR), so the consideration of issues should be proportionate.

6.6 The aim of the rapid review is to:

- 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 any 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 to undertake a Child Safeguarding Practice Review.

6.7 After reviewing all the information available against the criteria and guidance, the Rapid Review Panel will determine if it is considered whether the criteria for a CSPR have or have not been met.

6.8 If it is agreed that the CSPR criteria are met, the Rapid Review Panel Chair will provide a recommendation to the Statutory Safeguarding Partners as to whether a national or local review is appropriate. The Rapid Review Panel Chair may also make recommendations on the review methodology and whether an independent chair and/ or author is required.

6.9 If the Rapid Review Panel considers a CSPR should not be held, it may recommend another form of review or investigation is appropriate. This could include a single agency review or a smaller scale audit of agency involvement. This might be the case where for instance, there is a safeguarding element and lessons to be learned regarding the conduct of an agency, but where there is no or little concern regarding involvement from other agencies; or where it is considered that a broader scale review would be disproportionate to the concerns or to the learning.

6.10 Upon conclusion of the Rapid Review Panel, the outcome will be reported to the Statutory Safeguarding Partners/Independent Scrutineer who will make the final decision on the level of review. The Child Safeguarding Practice Review Panel will be informed of the decision about whether a CSPR is appropriate, or whether it is the view of the Rapid Review Panel that the case may raise issues which are complex or of national importance, such that a national review may be appropriate. The decision of the Statutory Safeguarding Partners and Independent Scrutineer/Chair will be reported to the Child Safeguarding Review Panel within **15 working days** of the acknowledgement of the receipt of the notification.

6.11 The Child Safeguarding Practice Review Panel will notify the Statutory Safeguarding Partners of the decision as to whether:

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

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

7. PURPOSE AND PRINCIPLES OF A CHILD SAFEGUARDING PRACTICE REVIEW

7.1 The purpose of a review is to promote effective learning and improvements to practice, through identifying what the relevant agencies and individuals involved in the case might have done differently, which could have prevented harm or death.

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

7.3 Some cases may not meet the definition of a 'serious child safeguarding case'; this may include cases where there has been good practice, poor practice or where there have been 'near-miss' events. The Statutory Safeguarding Partners may choose to undertake a Local Review in these, or other circumstances.

7.4 The level of the review will be determined by the Statutory Safeguarding Partners following a recommendation from the Rapid Review Panel.

7.5 Decisions on whether to undertake reviews should be transparent and the rationale communicated appropriately, including to families. If, following consideration, it is identified that it is not appropriate to conduct a review and the incident does not relate to the unexpected death of a child, the Statutory Safeguarding Partners will close the referral as no further action.

7.6 The Statutory Safeguarding Partners must also consider whether the case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including cases where those improvements have previously been highlighted;
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children;
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children;
- is one in which the Child Safeguarding Practice Review Panel has considered and concluded a local review may be more appropriate.

7.7 The Statutory Safeguarding Partners should also have regard to the following circumstances:

- where the Statutory Safeguarding Partners have cause for concern about the actions of a single agency;

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

8. COMMISSIONING A CHILD SAFEGUARDING PRACTICE REVIEW

8.1 The Statutory Safeguarding Partners are responsible for commissioning and supervising reviewers for a Child Safeguarding Practice Review (CSPR). In all cases it should be considered whether the reviewer has the following:

- professional knowledge, understanding and practice relevant to local child safeguarding practice reviews, including the ability to engage both with practitioners and children and families;
- knowledge and understanding of research relevant to children's safeguarding issues;
- ability to recognise the complex circumstances in which practitioners work together to safeguard children;
- ability to communicate findings effectively;
- whether the reviewer has any real or perceived conflict of interest.

8.2 The Statutory Safeguarding Partners will agree with the reviewer the method by which the review should be conducted. The methodology should provide a way of looking at and analysing frontline practice, as well as organisational structures and learning. The most appropriate methodology will normally be that which provides the best opportunity to learn; however, it will be determined by and proportionate to the specific circumstances and scale of the situation and should be able to reach recommendations which will improve outcomes for children. All reviews should reflect the child's perspective and family context *(see Appendix 3 for additional information on review tools and methodologies).*

8.3 The review should be conducted in accordance with NSPCC Quality Markers, which are designed to support commissioners and lead reviewers to conduct high quality reviews, by providing a consistent and robust approach to the process.

8.4 The review should be proportionate to the circumstances of the case, focus on potential learning, and establish and explain why events happened as they did.

8.5 As part of the duty to ensure that the review is of satisfactory quality, the Statutory Safeguarding Partners should seek to ensure that:

- practitioners are fully involved in reviews and invited to contribute their perspective, without fear of being blamed for actions they took in good faith;

- families, including surviving children, are invited to contribute to reviews. This is important for ensuring the child is at the centre of the process. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

8.6 The Statutory Safeguarding Partners must supervise the review to ensure that the reviewer is making satisfactory progress and the review is of satisfactory quality. The Statutory Safeguarding Partners may request information from the reviewer during the review, to enable them to assess progress and quality; such requests should be made in writing.

8.7 If the SSP have agreed to commission an independent author for the CSPR, this should be in line with the regionally agreed process for commissioning an Independent Author, through North East Procurement Organisation (NEPO).

9. CHILD SAFEGUARDING PRACTICE REVIEW – GOVERNANCE ARRANGEMENTS

9.1 In all CSPR's, a Governance Group will meet to agree the scope of the review and determine the Terms of Reference. The Governance Group will be chaired by the same Chair of the Rapid Review Panel.

9.2 The Statutory Safeguarding Partners will exercise the function of having oversight of the actions via the Learning and Development sub-group. The sub-group will ensure that identified improvement actions are completed, and any barriers or slippage in achieving outcomes are responded to. All improvement actions will be recorded in an action plan, which will be regularly reviewed and monitored by the sub-group, which will ensure that learning outcomes are embedded in the respective organisations. The actions will be monitored within an action log and exception report, which will be monitored by the sub-group.

The Chair of the sub-group will seek an explanation from relevant agencies in respect of outstanding actions and in accordance with the escalation process, will inform the relevant Head of Service in cases where actions are not completed three months beyond the specified deadline. The Chair of the sub-group will request confirmation of what action will be taken to rectify the matter. In cases where actions remain outstanding at six months beyond the original deadline, the Chair of the sub-group will inform the Chief Officer of the agency concerned and will seek information about what steps are being taken to complete the actions. An extension to the original deadline should only be agreed in exceptional circumstances and at the request of the Chief Officer. In exceptional circumstances, there may be a requirement for the Chair of the sub-group to involve the Statutory Safeguarding Partners in the escalation process.

9.3 Every effort should also be made before the review and whilst it is in progress, to capture points from the case about improvements needed and to take corrective action and disseminate learning.

10. REFERRAL TO THE LEARNING AND DEVELOPMENT SUB-GROUP - CASES THAT DO NOT MEET CRITERIA FOR SERIOUS CHILD SAFEGUARDING INCIDENT NOTIFICATION

10.1 Details of all serious child safeguarding incident notifications referred to the Statutory Safeguarding Partners (SSP) should be shared with the Chair of the Learning and Development sub-group in the interests of openness and transparency, to enable the sub-group to discuss and analyse the decisions made. Details of all cases will be referred to the sub-group on the referral template *(Appendix 2).*

10.2 Details of cases which an agency agrees do not meet the criteria for Serious Incident Notification, however highlights learning to be explored, should also be shared with the Chair of the Learning and Development sub group for consideration.

10.3 The SSP will have determined whether the case meets the criteria for notification to the Child Safeguarding Practice Review Panel. If the case meets the criteria, the Rapid Review Process will be followed, see section 6 above.

10.4 If the case does not meet the criteria for notification, the SSP will provide the rationale and decision.

10.5 Based on the information provided in the notification, the SSP will inform the Chair of the Learning and Development sub-group that there is no further action to be taken, or they recognise there is the potential for single or multi-agency learning.

10.6 The Learning and Development sub-group will then consider the information provided to determine:

1. Whether a multi-agency practice review should be undertaken;
2. Whether a multi-agency audit should be undertaken on similar cases;
3. Whether there is learning for a single agency and an internal review is undertaken;
4. Whether an issue is highlighted that needs to be explored further, through quality assurance processes;
5. No further action required.

10.7 The Learning and Development sub-group will provide details and the rationale and outcome of their decision to the SSP for approval, to progress course of action agreed.

11. INTERFACE WITH OTHER REVIEWS AND INVESTIGATIONS

11.1 There are several types of review and investigations that may interface with a Child Safeguarding Practice Review (CSPR) and it is important to identify any other processes which may be running in parallel or being considered. Important principles in planning include ensuring adherence to any separate statutory requirements, ensuring appropriate expertise and knowledge, reduction of duplication, maximising effectiveness and learning, and minimising the impact on those affected by the case. It is the responsibility of the Chair of the review panel to ensure contact is made with the Chair of a parallel process.

There are a number of types of review and investigation which may interface with a CSPR and it is important to consider any other processes which may be being considered. These may include:

- Safeguarding Adult Review (SAR)
- Domestic Homicide Review (DHR)
- Mental Health Homicide Reviews (MHHR)
- Safeguarding and serious incident investigations
- Disciplinary processes
- Judicial reviews
- Complaints
- Criminal justice processes
- YOS reviews
- Coroner inquests
- S 47 Child protection investigations
- Criminal investigations

11.2 The Statutory Safeguarding Partners must consider how the CSPR will interface with other processes or investigations. Important principles in planning include ensuring adherence to any separate statutory requirements, ensuring appropriate expertise and knowledge, reduction of duplication, maximising effectiveness and learning and minimising the impact on those affected by the case.

11.3 Where there are possible grounds for both a CSPR and a Safeguarding Adult Review (SAR) (or any other type of review), a decision should be made at the outset by the respective decision-making bodies as to how they will coordinate the reviews, engagement and report(s). This may result in some parts being jointly commissioned and overseen, or one body leading, with the same or different reports being taken to each commissioning body. This will necessitate a discussion between the Independent Scrutineer/Chair and the Chairs of other panels involved in a review to consider how best to proceed.

11.4 **Domestic Homicide Reviews;** Where there are possible grounds for both a Child Safeguarding Practice Review (CSPR) and a Domestic Homicide Review (DHR), a decision should be made by the Chair of the DHR and the Statutory Safeguarding Partners as to how they will coordinate the reviews, engagement and reports. This may result in some parts being jointly commissioned and overseen, or one body leading, with the same or different reports being presented to each body.

Where either the victim or suspect/perpetrator were responsible for the care of a child under the age of 18, the Chair of the Community Safety Partnership should inform the Darlington Safeguarding Partnership's Business Unit of the homicide and the circumstances.

For further information see Home Office Guidance Dec 2016: assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

11.5 Any CSPR will need to take account of a Coroner's enquiry and/or any criminal investigation including disclosure issues, which may impact on timescales. It will be the CSPR lead's role to ensure the necessary contacts are maintained with appropriate people.

12. ENGAGEMENT WITH FAMILIES

12.1 A core principle of safeguarding is to work with families in an open and honest way and this needs to be replicated in the Child Safeguarding Practice Review (CSPR). Being clear about the purpose and function of the CSPR helps manage the expectations of family members about what the CSPR can achieve. Within this context family are usually close relatives, including those with parental responsibility.

There is an increasing body of evidence that family members, including surviving children, can make a valuable contribution to professional understanding and should be invited to contribute to the review process. Consideration will be given to the earliest point in the process that the family will be involved. In all circumstances when information is to be shared between organisations, consent issues must be discussed and obtained for family members. Where it is deemed not appropriate to seek consent, the rationale for the decisions should be clearly recorded. A decision should be made at an early stage in the CSPR process about who is best placed to engage with the family.

13. CONSIDERATIONS FOR DISCLOSURE/INFORMATION SHARING IN A CSPR

13.1 The Statutory Safeguarding Partners/Safeguarding Partnership are not a public authority for the purposes of the Freedom of Information Act 2000.

13.2 Section 14B of the Children Act 2004 (as amended by the Children and Social Work Act 2017), sets out expectations in relation to information sharing between agencies and the Statutory Safeguarding Partners in relation to CSPRs, including an expectation that information must be shared to enable the Statutory Safeguarding Partners to fulfil their function.

13.3 Information must be shared in accordance with principles outlined in the Data Protection Act 2018 and General Data Protection Regulations and the Darlington Safeguarding Partnership Information Sharing Protocol.

13.4 Information sharing between the Statutory Safeguarding Partners and H.M. Coroner is not defined in statute however, case law in relation to information sharing has set a precedent. Once the Coroner has been informed that the Statutory Safeguarding Partners have commissioned a CSPR, information sharing in relation to CSPR documents should be considered on a case by case basis. On receipt of a request for documents relating to a CSPR from the Coroner, the Statutory Safeguarding Partners will seek legal advice in order to consider Public Interest Immunity arguments.

14. EXPECTATIONS FOR THE FINAL REPORT

14.1 The final Child Safeguarding Practice Review (CSPR) report should be completed in accordance with NSPCC quality markers (quality marker 14) and should clearly identify the analysis of the findings of the CSPR that are key to making improvements, whilst keeping details of the family to a minimum. There is often information about the case already in the public arena, for example, media publications and anonymised family court reports and much of this information is readily available on the internet. Therefore, personal and sensitive information about family members should not be included and precise details of the case should be minimised.

14.2 The main function of the report is to make accessible the analysis to support the necessary improvement work and the report should include the following:

- a summary of any recommended improvements to be made by persons in the area to safeguard and promote the welfare of children;
- provide an analysis of any systemic and underlying reasons why actions were taken or were not in respect of matters covered by the report.

14.3 Recommendations should be clear on what is required of relevant agencies collectively and individually within specified timescales and focussed on improving outcomes for children.

14.4 Reviews are about promoting and sharing information regarding improvements, both within the area and potentially beyond, and the Statutory Safeguarding Partners should publish the report unless it is considered inappropriate to do so. The name of the reviewer should be published and published reports or information about the improvement required must be publicly available for at least one year. In circumstances where it is deemed that publication is inappropriate, consideration should be given to the publication of information about any improvements which are required.

14.5 Once completed, the final report should be shared in the first instance with the Statutory Safeguarding Partners and the Independent Scrutineer/Chair before being presented to organisations within the wider partnership.

14.6 When compiling and preparing to publish the report the Statutory Safeguarding Partners should consider how to carefully manage the impact of the publication on children, family members, practitioners and others affected by the case. The Statutory Safeguarding Partners should ensure that reports are written in such a way that publication does not harm the welfare of children and vulnerable adults involved in the case.

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

15. MEDIA/COMMUNICATION AND PUBLICATION OF THE REPORT

15.1 The media strategy will be considered by the Rapid Review Panel/Governance Group at the beginning of the process, after the review has been commissioned and will be approved by the Statutory Safeguarding Partners. Media and communication issues will be coordinated by Darlington Borough Council Communications Team, in collaboration with the Communications Teams within the other Statutory Partner organisations and other agencies involved to ensure consistency.

15.2 In the interests of transparency, the Statutory Safeguarding Partners should consider publishing the CSPR report within legal parameters. The Statutory Safeguarding Partners/Independent Scrutineer will make the final decision on whether the CSPR report will be published in full or whether to publish only the learning outcomes. Advice will be sought from the Communications Teams within the Statutory Safeguarding Partner organisations, in respect of publication and media releases.

15.3 The Statutory Safeguarding Partners should also set out for the Panel and the Secretary of State, the justification for any decision not to publish either the full report or information relating to improvements. The Statutory Safeguarding Partners should have regard to any comments that the Panel or the Secretary of State may make in respect of publication.

15.4 At the point of publication, the Statutory Safeguarding Partners will release a press statement via the Communications Team outlining the reason for the review, the key findings and the required actions. The Statutory Safeguarding Partners will retain discretion over the process and timing of publication, considering such factors as ongoing criminal investigations or court proceedings.

15.5 Depending on the nature and complexity of the case, the report should be completed and published as soon as possible and no later than **six months** from the date of the decision to initiate a review. Where other proceedings may have had an impact on or delayed publication (for example, an ongoing criminal investigation, inquest or pending prosecution), the Statutory Safeguarding Partners should inform the Child Safeguarding Practice Review Panel and the Secretary of State of the reason for the delay. The Statutory Safeguarding Partners should also set out to the Child Safeguarding Practice Review Panel and the Secretary of State any decision not to publish either the full report or information relating to improvements. The Statutory Safeguarding Partners should have regard to any comments that the Child Safeguarding Practice Review Panel or the Secretary of State may make in respect of publication.

15.6 Every effort should also be made, both before the review and whilst it is in progress to:

1) capture points from the case about improvements and;
2) take corrective action and disseminate learning.

16. CONCLUSION AND DEBRIEF OF THE REVIEW

16.1 Once the review process has been completed, the Independent Reviewer will present the draft report to the Learning and Development sub-group, who have the governance responsibility for all reviews. The group will review the learning outcomes and suggested recommendations for improvement. The final draft report will be presented to the Statutory Safeguarding Partners and Independent Scrutineer/Chair for final sign off, before findings are shared with the wider multi-agency partnership group.

16.2 The Learning and Development sub-group will be responsible for determining the improvement actions, which will then be recorded into an action plan. This plan will be regularly reviewed and monitored by the Learning and Development sub-group, who will also ensure that learning outcomes are embedded in the respective organisations. The actions will be incorporated into an exception report which will be monitored by the sub-group. The Chair of the sub-group will seek an explanation from relevant agencies in respect of outstanding actions and in accordance with the escalation process, will inform the relevant Head of Service in cases where actions are not completed three months beyond the specified deadline. The Chair of the sub-group will request confirmation of what action will be taken to rectify the matter. In cases where actions remain outstanding at six months beyond the original deadline, the Chair of the sub-group will inform the Chief Officer of the agency concerned and will seek information about what steps are being taken to complete the action. An extension to the original deadline should only be agreed in exceptional circumstances and at the request of the Chief Officer.

17. ACTIONS IN RESPONSE TO LOCAL AND NATIONAL REVIEWS

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

18. ANNUAL REPORT

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

Appendix 1

CONFIDENTIAL

Notifiable (Serious) Incident Referral Form

This form is to be used for circumstances and/or events which either meet the criteria for notification and urgent reporting to the Director of Children and Adult Services at Darlington Borough Council (DBC) **OR** for reporting cases that do not meet the criteria for Serious Incident Notification, however highlight learning to be explored, which will be shared with the Learning and Development sub-group for consideration.
Complete as much information as is appropriate or known.

1. Reporting Details:

Please indicate whether this case meets the criteria for Serious Incident Notification or is a Learning request:	
Meets criteria for Serious Incident Notification: **Yes/No**	**Learning Request:** **Yes/No**

Date report:	
Who reported to:	
CC:	

From: **(Name and Job Title)**	
Organisation:	

Date of Incident:		
Does incident relate to the death of a child?	**YES**	**NO**
Date of Death:		
Does alleged incident involve the conduct of a staff member?	**YES**	**NO**

Send Completed Form securely to:	Darlington Safeguarding Partnership Business Unit Town Hall Darlington DL1 5QT E-mail – dsp@darlington.gov.uk Telephone: 01325 406450

2. Child details:

Child's last name:	
Child's forename:	
Child's middle names:	
Other names used:	

Date of birth:	
Age at time of incident:	

Gender:	
Ethnicity:	
Nationality:	

3. Parents/Guardians:

Parent's last name:	Parent's first name:	Date of birth:	Relationship to child:

4. Siblings:

Sibling's last name:	Sibling's first name:	Date of birth:	Relationship to child:	Gender:	Ethnicity:	Other Ethnicity:	Nationality: (if known)

5. Case details:

What is the main cause of incident? (click for drop down list) Choose an item.

What are the characteristics of the case (please tick where relevant)?

Alcohol abuse		Sexual Abuse		Parental Mental Health		Serious illness	
Domestic Violence		Fabricated illness		Parent is in care		Other	
Drug abuse		Recent Neglect		Child of teenage pregnancy		Not yet known	
Emotional abuse		Long-standing Neglect		Parent is care leaver			
Physical abuse		More than one child abused		Shaken baby syndrome			

6. Case outline:

Please provide a short outline of the case and the serious incident including any action taken after the incident to safeguard the child/sibling.

7. Child Protection

Was the child on Child Protection Plan (CPP) at the time of the incident?	**YES/NO**
Was the child on Child Protection Plan (CPP) prior to the incident?	**YES/NO**
Date CPP commenced:	
Date CPP ended:	

Child Protection Category (tick relevant)

Physical abuse		**Emotional abuse**	
Sexual abuse		**Neglect**	

Were any siblings on a Child Protection Plan (CPP) at the time of the incident?	**YES/NO**
Were any siblings on a Child Protection Plan (CPP) prior to the incident?	**YES/NO**

Name of Sibling:	**Date CPP commenced:**	**Date CPP ended:**	**Category of Abuse: (Physical/Sexual/Emotional/Neglect)**

8. Legal Status

What was the legal status of the child/young person at the time of the incident (click for drop down list)? Choose an item.

9. Disability

Did the child have a disability prior to the incident occurring, which affected any of the following?	**YES/NO**

Tick where relevant.

Behaviour		Hearing		Personal Care	
Communication		Incontinence		Vision	
Consciousness		Learning			
Hand Function		Mobility			

Please provide additional details:

10. Setting

Where was the child resident/placed at time of incident (click for drop down list)?
Choose an item.

Placement name (if applicable):	
Placement address:	
Placement sector (Local authority/Other):	

11. Education/ Early Years Provision

Did the child attend a college, school, child minder, nursery, or other early years provision at the time of the incident?	**YES/NO/DON'T KNOW**

Name of establishment (if applicable):	
Address:	
Ofsted Unique Reference Number (if known):	

12. Agency

Was the child known to Social Care or other agencies prior to the incident?	**YES/NO**

Please provide agency names:

Agency name:	Start Date:	End Date:

13. Criminal Proceedings:

Is the case linked to a complex abuse investigation?	**YES/NO**

Alleged abuser(s) and relationship to the child

Name:	**Relationship:**

Name of any person(s) charged and relationship to the child

Name:	**Relationship:**

Have Criminal Proceedings been instigated?	**YES/NO/DON'T KNOW**

14. Authorising Officer from within Agency and Comments:

Authorising Officer (name and job title): **Comments:**

15. Recommendation:

To be completed by Receiving Officer (Business Unit only)		
Date Referral Received:	If Serious Incident Notification – Date forwarded to Darlington Borough Council:	If Learning identified – date referred to Chair of Learning and Development sub-group:
Date notification referred to the Statutory Safeguarding Partners:		
Statutory Safeguarding Partners decision as to whether the notification meets the criteria for reporting to the Child Safeguarding Practice Review Panel. **Does meet the criteria for notification? ☐Yes ☐No** ***Summary of decision as to why it does or doesn't meet the criteria:*** **Date:**		
Date of notification to Child Safeguarding Practice Review Panel:		
Feedback and outcome of notification to reporting agency: ***Date:*** ***Who notified****:*		

Appendix 2

Serious Child Safeguarding Incident

Referral template

Learning and Development Sub-Group

Date referred to Learning and Development Sub-Group:	
Date Serious Incident Notification received by Darlington Borough Council:	
Organisation submitting the Notification:	
Date notification referred to Statutory Safeguarding Partners:	
Decision by Statutory Safeguarding Partners as to whether the notification meets the criteria for reporting to the Child Safeguarding Practice Review Panel	Yes/No If yes, Rapid Review Process is followed
If decision is made not to submit notification to the National Panel, rationale and decision as to why not:	
What information was shared to enable the partners to make the decision that it did not meet the criteria for notification *(include agency details, where applicable).*	
Based on the information provided and the criteria for notification was not met, do Statutory Safeguarding Partners recognise there may be learning from the case?	Yes/No If no, there should be no further action taken and decision to be shared with Chair of Learning and Development sub-group for information.

	If yes, refer to Chair of Learning and Development sub-group for consideration on next steps. *(Provide copy of referral form and decision notes for information)*
Date of Learning and Development sub-group meeting:	
Agencies Present:	
The Learning and Development sub-group to determine: 1. Whether a multi-agency practice review should be undertaken 2. Whether a multi-agency audit should be undertaken on similar cases 3. Whether there is learning for a single agency and an internal review is undertaken 4. Whether an issue is highlighted that needs to be explored further, through quality assurance processes 5. No learning or further action required	Outcome of decision and rationale:
Rationale and outcome of decision by Learning and Development sub-group shared with Statutory Safeguarding Partners Date:	

Appendix 3

Child Safeguarding Practice Review Methodologies

Traditional Model

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

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

Individual Management Reviews (IMR)

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

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

Where it is decided that IMRs are required:

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

Multi-Agency Chronology

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

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

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

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

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

Advantages and Disadvantages of Traditional Review Approach

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

Advantages:

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

Disadvantages:

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

Action Learning Approach

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

The broad methodology is:

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

Further variance

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

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

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

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

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

Advantages and disadvantages of action learning review approach are outlined below

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

Advantages:

- significant evidence approach is much more efficient;
- swiftness of conclusion and embedding the learning.

Action learning approach enhances:

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

Disadvantages:

- methodology less familiar to many.

Peer Review Approach

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

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

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

Advantages and disadvantages of peer review approach

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

Advantages:

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

Disadvantages:

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

Multi-Agency Practice Learning Review

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

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

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

Root Cause Analysis (RCA)

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

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

Significant Event Analysis (SEA)

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

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

Appendix 4

Information template for Rapid Review Consideration

In line with Working Together to Safeguard Children 2018 and Children Act 2004 (as amended by the Children and Social Work Act 2017), where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if:

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

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

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

a) the child dies; or
b) a child is seriously harmed and there are concerns as to the way in which the Statutory Safeguarding Partners, the Safeguarding Partnership or other relevant persons have worked together to safeguard the child.

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

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

Identify the nature of your agency's involvement with the child/children/family and any safeguarding issues that you are aware of during your involvement.
At this time, what factual information is known about the incident by your agency.

Appendix 5

DARLINGTON SAFEGUARDING PARTNERSHIP

Rapid Review Panel Meeting

Date of Rapid Review Panel:	
Present:	
Apologies:	
Date of notification to: **Child Safeguarding Practice Review Panel:** **Statutory Safeguarding Partners**	
Welcome/Reason for meeting:	
Factors about the case; as far as they can readily be established at the time of this meeting:	
Details of agency Involvement with the family and child/ren: **i.e. Children Social Care, Durham Constabulary etc.**	
Is there any immediate action needed to ensure child/ren and sibling safety?	

Has the panel identified improvements necessary to safeguard and promote the welfare of children?	
Are there any factors identified that indicate the case may be of National importance?	
Outline the panel's recommendations regards: **Decision:** **Rationale:** **Next Steps:** **Including decisions as to whether to undertake a Child Safeguarding Practice Review**	

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

Appendix 6

Chronology:

Name: DOB:

Address:

Agency: Author:

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

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