Kent Safeguarding Children
multi-agency partnership

Practice Improvement Framework

18th November 2019

Who is the Guidance for?

This practice guidance should be read by local safeguarding partners, and all agencies involved in the new Kent Safeguarding Children Multi-agency Partnership (KSCMP) arrangements, that replaced Local Safeguarding Children Boards. The guidance is particularly aimed at those involved in undertaking or contributing to Local Child Safeguarding Practice Reviews, (LCSPR), such as Independent Lead Reviewers, Rapid Review Team members, Review Panel members, those providing information reports on behalf of their organisation as well as those responsible for quality assuring and embedding the learning from the review process.

About this Guidance

This guidance provides KSCMP with a framework for the commissioning and dissemination of learning from LCSPR. It should be read alongside the relevant statutory guidance set out in:

- *Working Together to Safeguard Children (2018)*
- *Working Together: transitional guidance (2018)* https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
- Child Safeguarding Practice Review Panel guidance https://www.gov.uk/government/publications/child-safeguarding-practice-review-panel-practice-guidance

The framework and guidance has been endorsed by the Executive Board of the KSCMP: the guidance will be reviewed and updated to reflect changes in national guidance and emerging good practice.

Introduction and Context

Introduction

The Children and Social Work Act 2017 introduced a new legal framework in respect of local safeguarding arrangements for children. Responsibility for how a system learns lessons from serious child safeguarding incidents now rests at a national level with the Child Safeguarding Practice Review Panel (CSPRP), and at a local level, with the three Safeguarding Partners (Clinical Commissioning Groups, Police and Local Authorities). Local areas will no longer conduct Serious Case Reviews. Instead, they need to consider whether to conduct a LCSPR in cases where abuse or neglect of a child is known or suspected, and the child has died or been seriously harmed.

This guidance outlines the Kent process for commissioning and undertaking LCSPRs. It demonstrates a real commitment to be an improving and learning system, determined to make best use of resources (human and financial) in the best interests of children and families

Appendix A of this guidance provides professionals with a step by step approach to undertaking or participating in a LCSPR. It describes the approach, order of events and related timescales whilst

also highlighting the key statutory elements outlined in *Working Together to Safeguard Children 2018.* It also outlines responsibilities for key people at every stage of the process and includes template documents and letters.

Purpose and Criteria for LCSPRs

The purpose of a child safeguarding practice review is to explore how practice can be improved through changes to the system itself. Reviews should seek to understand both why mistakes were made and to comprehend whether mistakes made on one case frequently happen elsewhere and to understand why.[1]

Holding organisations and their leaders to account for the quality of services, and individuals to account for not meeting professional standards are essential prerequisites for public confidence in the national safeguarding system. Regulatory bodies for the professions hold this key role. Reviews are not designed for this purpose and will not be used in this way. Nevertheless, where reviews identify any actual or potential errors or violations, they should ensure that proper lines of accountability are followed to ensure that those responsible are held to account.

Definition of a Serious Child Safeguarding Case

Working Together 2018 defines serious child safeguarding cases as those in which: abuse or neglect of a child is known or suspected, **and** the child has died or been seriously harmed.

Serious harm includes, (but is not limited to), impairment of physical health **and** serious / long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development.

Working Together 2018 advises that consideration be given to whether impairment is likely to be long-term, even if this is not immediately obvious. Even if a child recovers, serious harm may still have occurred.

Child perpetrators may be the subject of a review, if the definition of a serious child safeguarding case is met.

Criteria for a LCSPR

Safeguarding Partners are required[2] to consider certain criteria and guidance when determining whether to carry out a LCSPR. They **must take into account** whether the case:

[1] This definition is taken from the Practice Guidance issued by the National Child Safeguarding Review Panel on 5 April 2019.

[2] by the Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018.

- 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 that a local review may be more appropriate.

They should also **have regard to** the following circumstances:

- 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.[3]

Meeting the criteria does not mean a LCSPR must automatically be undertaken. Instead, the process outlined in this document will be followed to determine whether a review is appropriate (i.e. whether there is potential to identify improvements.)

LCSPRs may also be undertaken for cases which do not meet the definition of a 'serious child safeguarding case' if they raise issues of importance that could generate learning. *Working Together 2018*, for example, suggests they might take place where there has been good practice, poor practice or where there have been 'near miss' events.

Alternative learning reviews will always be considered if the decision is not to proceed with a formal LCSPR. Each case must be considered individually, and due regard given to links with the Kent and Medway Safeguarding Adult's Board and their undertaking of Serious Adult Reviews, and the undertaking of Domestic Homicide Reviews.

Approach and Principles

Kent has agreed that the approach to LCSPRs will be 'systems based'. Each case will, however, be examined individually to determine the most appropriate methodology to identify and maximise learning.

[3] This includes children's homes (including secure children's homes) and other settings with residential provision for children; custodial settings where a child is held, including police custody, young offender institutions and secure training centres; and all settings where detention of a child takes place, including under the Mental Health Act 1983 or the Mental Capacity Act 2005.

We will conduct LCSPRs and other learning reviews in line with good practice and the principles of the systems methodology recommended by the Munro Report.[4] This includes the advice outlined in *Working Together 2018* and its predecessor documents, as well as the good practice principles described in the Social Care Institute for Excellence (SCIE) / National Society for the Prevention of Cruelty to Children (NSPCC) 'Quality Markers'[5].

Decisions on whether to undertake a review will be made transparently and the rationale shared with all relevant partners, including families.

The child will be placed at the centre of the process.

All reviews will be proportionate to the circumstances of the case and focus on the potential learning. Specifically all reviews will be conducted in a way which:

- reflects the child's perspective and family context;
- considers and analyses frontline practice as well as organisational structures and learning;
- establishes the reasons why events occurred as they did; and
- reaches recommendations that will improve outcomes for children.

Families, including surviving children, will be invited to contribute to reviews unless there is a strong reason not to. Steps will be taken to sensitively manage their expectations and ensure they understand how they are going to be involved.

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

All participants in the review process will be asked to declare any potential conflicts of interest and will be expected to sign, and adhere to, a confidentiality agreement.

Strategic Leadership and Governance

The CSPRP does not have the power to require Local Safeguarding Partners to undertake reviews. Ultimately, the decision to proceed to a LCSPR is always a local decision, for which local Safeguarding Partners are accountable. This includes the identification of cases, commissioning and supervising of reviews, and the publication of reports and embedding learning.

We have established a Rapid Review Group, made up of representatives from the Safeguarding Partners, along with any safeguarding experts from relevant partner agencies. This Group will

[4] The systems approach in this guidance was developed based on the model cited in the Munro Report: this is described in SCIE Guide 24: *'Learning together to safeguard children: developing a multi-agency systems approach for case reviews'* by Dr Shelia Fish, Dr Eileen Munro and Sue Bairstow (January 2009).

[5] Social Care Institute of Excellence (SCIE) and NSPCC's '*Serious Case Review Quality Markers: Supporting dialogue about the principles of good practice and how to achieve them'* (March 2016). Although these were developed for serious case reviews, most of the principles are transferable.

convene when a serious incident is referred to them. This Group will undertake a Rapid Review of each serious incident referred to them and will take responsibility for commissioning and overseeing any LCSPRs or alternative learning reviews. This will include monitoring case progression, quality assurance and publication of final reports, and ensuring effective oversight of the implementation of learning.

The KSCMP Executive Board have agreed that this decision will be made by the members of the Rapid Review Group. The decision will be passed to the CSPRP by the Partnership Team, who will be the key link between the Panel and the Partnership.

All decisions related to the commissioning and publication of LCSPRs will be notified to the CSPRP, the Department for Education and Ofsted.[6]

[6] This is separate from the formal requirement on local authorities in England to notify the national Child Safeguarding Practice Review Panel and the relevant local safeguarding partners if a child dies or is seriously harmed in their area (or outside of England while they are normally resident in the local authority area) and their duty to notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected.

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Appendix A

Rapid Review Process

Notification

Agencies should inform the relevant designated single point of contact for the Safeguarding Partners of any serious incident which they think should be considered for a LCSPR, using the KSCMP electronic ePR Case Notification Form, (https://www.qes-online.com/Kent/ECR/live/Login).

Local authorities have a separate duty to:

- notify the national CSPRP if a child dies or is seriously harmed in their area (or outside of England while they are normally resident in the local authority area);
- notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected.

Where the Local Authority makes a formal notification to the CSPRP or Ofsted, it must always submit a formal notification to the Safeguarding Partners (as above).

Where the Safeguarding Partners receive a notification from a Partner Agency that does not meet the criteria for an Ofsted notification by the Local Authority, this matter will still be brought to the attention of the Rapid Review Group who will give appropriate consideration to the case and make a decision as to whether a local LCSPR is to be undertaken.

Deciding whether to undertake a LCSPR

Rapid Review

Rapid Reviews should assemble the facts of the case as quickly as possible in order to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning.

Initial Scoping, Information Sharing and the Securing of Records

All agencies who have had involvement with the subject child, or family, will be required to contribute to a Rapid Review. An initial scoping of agencies' intervention will, therefore, need to be completed and other relevant information will need to be rapidly gathered.

The purpose of the initial scoping and information sharing is to gather the basic facts about the case, including determining the extent of agency involvement with the child and family. More detailed information will be sought if the Rapid Review concludes the case has the potential to identify national or local learning and a decision is made to progress to a formal LCSPR or alternative Learning Review.

All agencies should also secure all records/files in relation to the case, ensuring they are removed to a secure place where they are not accessible to agency personnel other than through a nominated representative. Where access to the records is required for ongoing case work, a copy should be made and secured.

Where the notification relates to a Child Death, consideration could be given to the use of Agency Child Death Overview Process (CDOP) Form A's and Form B's as a way of obtaining agency involvement in a more timely manner and, providing the detail recorded is of sufficient quality on which to base a discussion and make recommendations, this will avoid duplication of work by the agencies. Where the notification does not involve a Child Death, agency summaries will be required.

The Rapid Review meeting

The Rapid Review meeting should:

- review the facts about the case as presented in the documentation;
- discuss whether any immediate action is needed to ensure children's safety;
- identify immediate learning that can be acted upon and agree how this will be shared. (This may negate the need for further review).
- consider the potential for identifying improvements to safeguard and promote the welfare of children;
- decide whether or not to undertake a LCSPR. If the decision is not to proceed with a formal LCSPR, the Group will consider whether an alternative form of Learning Review is appropriate.

The Rapid Review Template should be completed and agreed at this meeting.

Membership of the Rapid Review Group:

- Assistant Director Safeguarding and Quality Assurance, KCC Integrated Children's Services
- Detective Superintendent/Detective Chief Inspector, Protecting Vulnerable People Command, Kent Police
- Designated Doctor/Designated Nurse
- Partnership Team Manager
- Education representation

Other Partners may be co-opted on to the Rapid Review Group as required on a case by case basis.

Documentation

The following documents should be shared with all those attending the Rapid Review meeting:

- the completed *Practice Review Notification Form* that initiated the process;
- the *Local Authority Serious Incident Notification to Ofsted*, Department for Education and the CSPRP in relation to the incident (if completed);

- copies of the completed *Initial Scoping and Information Sharing* templates from relevant agencies.

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

The Rapid Review Group meeting discussion and decisions will be formally minuted.

Decision making

A decision on the outcome of the Rapid Review meeting, must be made by the Partnership before being passed to the CSPRP, at (Mailbox.NationalReviewPanel@education.gov.uk) together with supporting documentation and a covering letter.

The Rapid Review Group will ensure that the Partnership's Executive Board is apprised of its decisions and the CSPRP response. Resolution for any disagreement within the Rapid Review Group, will be referred to the Chair of the Executive Board.

In addition to the feedback from the CSPRP to the Rapid Review Group's decisions and submissions, the Independent Scrutineer will undertake 6 monthly reviews of the Rapid Review Group process and decisions, reporting their views on the effectiveness of the Group to the Executive Board.

Other agencies, (including the agency who made the referral), should also be informed of the outcome of the Rapid Review. Individual agencies should notify their own inspectorate bodies as required.

Timetable of required Rapid Review activity

Incident/event (Date)	Local Authority notification to the CSPRP and the KSCMP Partnership Team within 5 days of the incident/event	
Agency summary request	On receipt of the notification, Partnership Team to send out the request to Practice Review Single Points of Contacts (SPOCs)	Day 1
Agency summaries	Commissioned by agency SPOCs and returned to the Partnership Team within 9 days	Day 10
Summaries collated	Partnership Team collate and produce a report on the case	Day 11
Send out papers	Partnership Team to send out the report to the Rapid Review Group members for review and response	Day 12
Rapid Review Group meeting and decision	Rapid Review meeting[7] called to discuss the case and make a decision as to the undertaking, or not, of any review	Day 14
Notify CSPRP	Partnership Team send the outcome of the Rapid Review to the CSPRP	Day 15

[7] Where absolutely essential to meet the required timescales, extraordinary meetings may be held via tele-conference.

Information Sharing

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

The Safeguarding Partners have the formal authority to request information to support both National and LCSPRs and the power to take legal action if information is withheld without good reason.

All agencies will be expected to share relevant information within the timescales requested. This may, when necessary, include sharing information without consent (such as where there is an ongoing police investigation). This includes information about parents, guardians and other family members as well as the child(ren) who are subject of the review.

Where a request is for health records this applies to all records of NHS commissioned care whether provided under the NHS or in the independent or voluntary sector.

When making requests for information, the Safeguarding Partners will consider their responsibilities under the relevant information law and have regard to guidance provided by the Information Commissioner's Office.

Good practice principles around information sharing will always be followed, particularly around 'how' information is shared. For example, when responding to requests for information, agencies should:

- Identify how much information to share;
- Distinguish fact from opinion;
- Ensure that they give the right information to the right individual;
- Ensure that they share information securely;
- Where possible, be transparent with the individual, informing them that the information has been shared (as long as doing so does not create or increase the risk of harm);
- Record all information sharing decisions and reasons in line with organisational procedures.

In the case of any disagreement or failure to comply with a formal information request, the Independent Lead Reviewer will refer the issue to the local Practice Review Panel (where one is in place) or the Rapid Review Group, who will seek to resolve this with the strategic Safeguarding Lead for the agency concerned. If a prompt resolution cannot be found, the issue will be escalated to the Safeguarding Partners for formal action.