Kent Safeguarding Children
multi-agency partnership

Practice Improvement Framework

9th March 2020

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

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 the Local Authority's notification of serious incidents to the CSPRP, the undertaking of Rapid Reviews and correspondence with the CSPRP in relation to these Rapid Reviews, and the commissioning and undertaking of LCSPRs where the case has not met the criteria for a Local Authority notification to the CSPRP. 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.

It has been decided that the oversight of notifications and any subsequent review will be managed in two distinctly different ways:

- Rapid Reviews will be managed through the Partnership's Rapid Review Group. This Group is made up of senior representatives from the three statutory Safeguarding Partners. The Chair of this Group will rotate on a yearly basis. In year one, it will be chaired by the Local Authority.
- Cases that do not meet the criteria for a Local Authority notification to the CSPRP, but where a Partner agency feels that the case meets the criteria for LSCPRs (see below), these cases will be managed through the Partnership's Practice Review Group. The membership of this Group includes the statutory Safeguarding Partners, plus senior managers from Relevant Agencies (See the KSCMP Safeguarding Agreement), a Lay Member and any other agency that it is felt appropriate to include for that case.

A summary of this process is outlined at Appendix A.

Appendix B of this guidance provides professionals with a step by step approach to undertaking or participating in a Rapid Review. 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.

Appendix C outlines the process for commissioning, conducting and publishing LCSPRs.

Duty on local authorities to notify incidents (Serious Child Safeguarding Cases) to the CSPRP

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 CSPRP if:

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

The local authority must notify any event that meets the above criteria to the CSPRP. They should do so within five working days of becoming aware that the incident has occurred.

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.

These cases will always result in the Partnership undertaking a Rapid Review, therefore, the local authority must also report the event to the KSCMP within five working days using the following link: https://www.qes-online.com/Kent/ECR/live/Login. The notification to the partnership will include an initial assessment of the key areas for specific consideration in the undertaking of a Rapid Review.

The local authority must also notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected. These case may not result in a Rapid review.

The duty to notify events to the CSPRP rests with the local authority. Others who have functions relating to children should inform the safeguarding partners of any incident which they think should be considered for a child safeguarding practice review, (See appendix B).

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 three statutory Safeguarding Partners. This Group will convene following the Partnership being informed that the Local Authority has made a notification of a serious incident to the CSPRP. This Group will undertake a Rapid Review of each serious incident referred to them.

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 Chair of the Rapid Review Group, who will be the key link between the Panel and the Partnership.

Following the undertaking of a Rapid Review, the Rapid Review Group will take responsibility for commissioning and overseeing any decided 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. Guidance for undertaking these reviews is included in Chapter 4 of Working Together 2018.

All decisions related to the commissioning and publication of LCSPRs will be notified to the CSPRP.

Purpose of 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

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

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.

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:

- 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' (not requiring a Local Authority Notification to the CSPRP), if they raise issues of local 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. Such cases should be notified to the KSCMP using the following link: https://www.qes-online.com/Kent/ECR/live/Login

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.

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

[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.

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.

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.

[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.

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, this will be referred to the 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.

Appendix A

See attached flow chart

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Appendix B

Rapid Review Process

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.

The aim of the rapid review is to enable safeguarding partners 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 or not to undertake a child safeguarding practice review

The rapid review should conclude with a recognition of the learning that the case offers, (both repeated learning from previous reviews, and new learning specific to this case), what action has already been taken to address this learning, any recommendations for further activity to address the learning and the decision about whether or not a local child safeguarding practice review should be commissioned using the criteria set out in Working Together (2018).

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, recognition of the learning that the case offers, (both repeated learning from previous reviews, and new learning specific to this case), what action has already been taken to address this learning, any recommendations for further activity to address the learning.

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.

Rapid Review Group

Membership of the Rapid Review Group:

- Director Integrated Children's Services (Social Work Lead)
- Detective Superintendent/Detective Chief Inspector, Protecting Vulnerable People Command, Kent Police
- Designated Doctor/Designated Nurse
- Partnership Team Manager

The Rapid Review meeting

The Rapid Review meeting should record:

- whether or not the case in question is being considered against the criteria set out in Working Together (2018);
- 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 local child safeguarding practice review have been met and on what grounds, and if not, why not. Clear reasons are required;
- a recommendation on whether or not a national review would be considered necessary, and if so, why. Clear reasons are required;
- any immediate learning already established and plans for their dissemination;
- potential for additional learning;
- if the decision is taken not to proceed with a 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; and,
- relevant identifying details of the child and family.

Documentation

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

- the completed Notification Form that initiated the process;
- the Local Authority Serious Incident Notification to the CSPRP in relation to the incident;
- 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.

A 'good' Rapid Review report is one that sets down:

- 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 for the learning and recommendations;
- a summary of why relevant decisions by professionals were taken;
- a critique of how agencies worked together and any shortcomings in this;
- whether any 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; and,
- what needs to happen to ensure that agencies learn from this case.

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[6] called to discuss the case and make a decision as to the undertaking, or not, of any review	Day 14
Notify CSPRP	Rapid Review Group Chair sends the outcome of the Rapid Review to the CSPRP	Day 15

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

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Appendix C

Local Child Safeguarding Practice Reviews

The safeguarding partners, through the Rapid Review Group should agree the method by which the review should be conducted, taking into account this guidance and the principles of the systems methodology recommended by the Munro review.

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 should be proportionate to the circumstances of the case, focus on potential learning, and establish and explain the reasons why the events occurred as they did.

As part of their duty to ensure that the review is of satisfactory quality, the safeguarding partners should seek to ensure that:

- practitioners are fully involved in reviews and invited to contribute their perspectives 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 that 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.

The safeguarding partners must supervise the review to ensure that the reviewer is making satisfactory progress and that the review is of satisfactory quality. The safeguarding partners may request information from the reviewer during the review to enable them to assess progress and quality; any such requests must be made in writing. The President of the Family Division's guidance covering the role of the judiciary in SCRs should also be noted in the context of child safeguarding practice reviews.

Commissioning a reviewer for a local child safeguarding practice review

The safeguarding partners are responsible for commissioning and supervising reviewers for local reviews.

In all cases they should consider 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 understand practice from the viewpoint of the individuals, organisations or agencies involved at the time rather than using hindsight
- ability to communicate findings effectively

- whether the reviewer has any real or perceived conflict of interest

Conducting the Review

LCSPRs will be conducted in line with the CSPRP Practice Guidance section of this guidance and will have a systems learning approach.

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

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- practitioners are fully involved in reviews and invited to contribute their perspectives 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 that 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.

Expectations for the final report

Safeguarding partners must ensure that the final report includes:

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

Recommendations

Any recommendations should be clear on what is required of relevant agencies and others collectively and individually, and by when, and focussed on improving outcomes for children.

All recommendations will be monitored and overseen by the safeguarding partners through the Partnership Team. Single and multi-agency action plans will be produced in order to address the report's recommendations. The safeguarding partners will receive regular reports as to the agencies' progress against their agreed actions.

Embedding learning from LCSPRs

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

i. capture points from the case about improvements needed, and
ii. take corrective action and disseminate learning.

The safeguarding partners and relevant agencies are committed to learning from LCSPRs and will take responsibility for ensuring that their staff are fully briefed on the learning, as well as providing evidence as to how this learning is impacting on frontline practice.

Publication of the Final Report

Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond, so safeguarding partners must publish the report, unless they consider it inappropriate to do so. In such a circumstance, they must publish any information about the improvements that should be made following the review that they consider it appropriate to publish. The name of the reviewer(s) should be included. Published reports or information must be publicly available for at least one year.

When compiling and preparing to publish the report, the safeguarding partners should consider carefully how best to manage the impact of the publication on children, family members, practitioners and others closely affected by the case. The safeguarding partners should ensure that reports are written in such a way so that what is published avoids harming the welfare of any children or vulnerable adults involved in the case.