# Serious Child Safeguarding Incidents and Safeguarding Practice Reviews: Pan-Sussex Guidance and Procedure

**Updated February 2023**

## Contents

## 1. Introduction

A key statutory[i] function of Safeguarding Children Partnerships is to conduct a Local Child Safeguarding Practice Review after a child has died or is seriously harmed[1] as a result of abuse or neglect within the Local Authority area.

For the purposes of this guidance the East Sussex, West Sussex and Brighton & Hove Safeguarding Children Partnerships (ESSCP; WSSCP and BHSCP) will be referred to as the Pan-Sussex Safeguarding Children Partnerships "PSSCP" and will follow this guidance in their *individual* 'local authority' areas. Individual Safeguarding Partnerships will be referred to as "SCP".

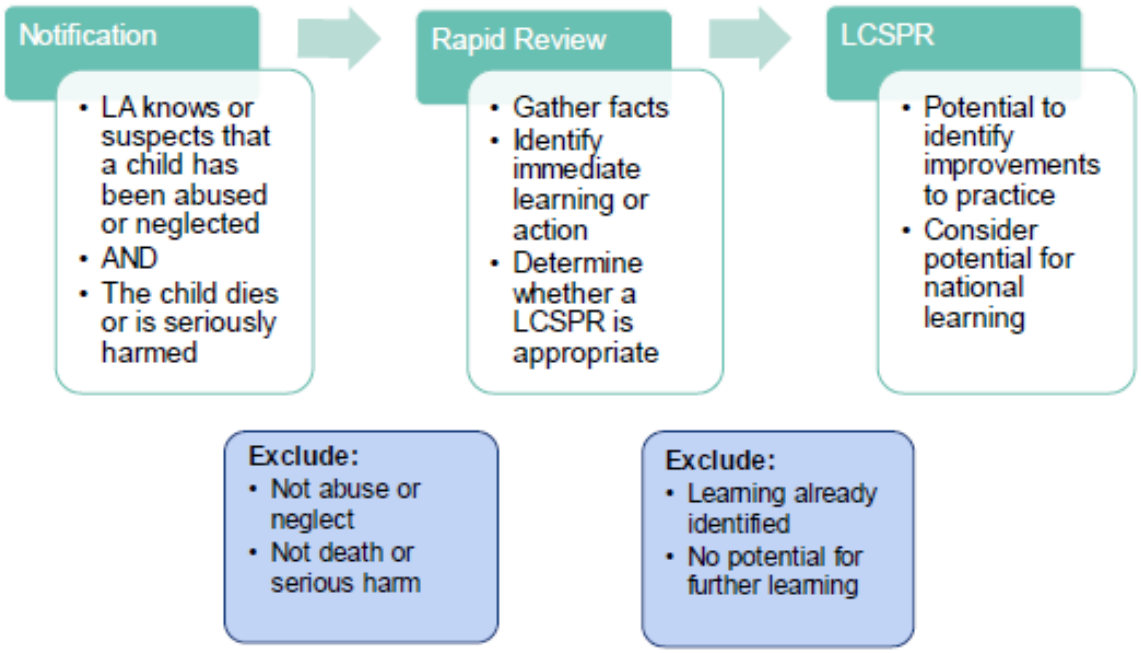
In each SCP area the partnership Case Review Group (CRG) is responsible for this process including:

- Recommendations on behalf of the three safeguarding lead partners and inviting the independent scrutineer/chair to provide objective feedback regarding the recommendation as to:
  - whether a child safeguarding practice review should be carried out and the methodology/approach to be used, or
  - whether a child safeguarding practice review should not be carried out but another type of action, such as a single agency review or audit should be undertaken, or
  - whether other action should be taken by the SCP
- Commissioning local child safeguarding practice review on behalf of the SCP
- Monitoring partner agency, and SCP's action plans following the publication of child safeguarding practice reviews
- Using the learning from local and national child safeguarding practice reviews to inform policy, practice and the SCP's learning and development programme

The National Panel issued updated Child Safeguarding Practice Review guidance for safeguarding partners in September 2022, which should be considered alongside this procedure. This updated guidance included the helpful graphic shown below, which outlines decision making around reviews.

[1] Serious harm includes (but is not limited to) serious **and/or** long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred. Working Together 2018.20……

How to undertake these steps will be detailed in this Serious Child Safeguarding Incidents and Safeguarding Practice Reviews Pan-Sussex guidance and procedure.




## 2. Serious Child Safeguarding Incidents

The responsibility for how the safeguarding system learns the lessons from serious child safeguarding incidents lies at a national level with the National Child Safeguarding Practice Review Panel (NCSPRP) and at local level with the SCPs. Each SCP has arrangements in place to ensure that serious child safeguarding incidents are identified and reviewed in line with Working Together 2018.

**Serious child safeguarding cases are those in which:**

**a) the child has died or been seriously harmed, and**

**b) abuse or neglect of a child is known or suspected.**

Serious harm includes life-changing or long-term injury or an injury that is clearly life-threatening, serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development and impairment of physical health.

A serious child safeguarding case is one in which issues of local importance are raised, including effectiveness of multi-agency safeguarding practice, and in such matters each SCP will consider what action should be taken. In assessing whether an incident

or case is a 'serious child safeguarding case' - SCPs should consider whether the case highlights improvements needed (including where those improvements have been previously identified), highlights recurrent themes, or concerns how two or more organisations work together.

Determining the level of seriousness will sometimes need consideration and in some cases this may be difficult, for example in the cases of severe neglect, in such cases a judgement about the seriousness will need to be made.

## 3. Identifying and Referring Serious Child Safeguarding Cases

**Each agency must have their own arrangements for identifying serious child safeguarding cases or incidents where serious harm or death has occurred. It is important that any practitioner or professional can discuss a case or incident with their agency safeguarding children lead if they think it is a serious child safeguarding matter.**

Many cases of serious harm become known through a critical incident or the death of a child, in which case the local area Multi Agency Safeguarding Hub (MASH) will be alerted and will notify the Local Authority Director of Children's Services, Assistant Director of Social Care and Head of Safeguarding Children. An initial assessment on whether a Serious Incident Notification is needed will be made. However, CRG can receive referrals from any professional working in a children's service.

If there is no critical incident or death, then any partner agency may refer a case to the SCP CRG if they believe that there are important lessons for multi-agency working to be learned from the case. The agency safeguarding lead should notify the SCP Manager of a referral using the CRG Serious Incident referral form (Appendix A). The SCP Manager will advise the members of CRG of the referral, who will have an initial discussion on whether a Serious Incident Notification is required.

## 4. Serious Incident Notifications

If (a) a child dies or has been seriously harmed, and (b) abuse or neglect is known or suspected – a decision on whether to submit a Serious Incident Notification (SIN) to the National Child Safeguarding Panel must be made.

The SCP for the area in which the child is normally resident decides whether an incident should be notified.

As mentioned above, some cases will be more difficult than others to decide if the case needs a Serious Incident Notification. In cases such as these where the CRG members are undecided or have a split opinion, the SCP Business Team will facilitate discussion between the three safeguarding leads (namely: Children's Social Care, NHS and Police) for a SIN decision. Sufficient but brief information will be shared to enable a multi-agency decision to be made. Where a SIN is to be made, the National Child Safeguarding Review Panel should be notified within 5 days of the local authority first becoming aware of the incident.

The duty to submit the formal notifications of a child death or serious harm rests with the Local Authority (completed by Local Authority Head of Safeguarding Children). However, this guidance supports that the assessment and decision on whether the criteria for notification is met should be made in consultation with safeguarding leads. The Local Authority must also notify Secretary of State and Ofsted where a child looked after has died, whether or not abuse or neglect is known or suspected.

Once a Serious Incident Notification has been submitted, this will trigger a SCP Rapid Review.

## 5. Rapid Reviews

A Rapid Review will take place following submission of a Serious Incident Notification to the National Panel.

The rapid review provides an opportunity for agencies to reflect on their safeguarding practice relating to system and practice issues and identify immediate improvements and learning. The rapid review information will be requested from agencies using the rapid review information request template (Appendix B). This will be co-ordinated by the SCP business team.

The aim of a 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
- Understand the child's lived experience
- 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 CRG will convene to discuss and analyse agency submissions with a view to deciding whether a Local Child Safeguarding Practice Review (LCSPR) should be undertaken and identifying immediate improvements and learning.

Statutory Safeguarding Partner Leads delegate responsibility for decision making with regards to rapid review outcomes to their CRG representatives, of whom hold appropriate seniority, knowledge and experience to undertake this task. Statutory Safeguarding Partner Leads have oversight of recommendations and decision making. A rapid review report containing the CRG decision on whether to undertake a LCSPR or not will be submitted to the SCP statutory safeguarding leads and SCP Independent Scrutineer/chair for review. The rapid review report will then be sent to the National Child Safeguarding Review Panel. This should be done within 15 working days of the SIN being submitted. Any delays on making the decision or submission of the rapid review report should be communicated directly to the National Review Panel.

Rapid Reviews should include:

- Date of birth, gender and ethnicity of the child who has been harmed or who has died and whether the child had any known disability
- Family structure and relevant background information on the family – include all children not just the one(s) harmed or who died. A family tree (genogram) is often helpful. Relevant information should be provided on the parents and any significant adults, including ages and any known physical or mental health problems or disability
- Immediate safeguarding arrangements of any children involved
- Which agencies have been involved in the rapid review, explaining any agency omission whose involvement would be usually expected
- A concise summary of the facts, so far as they can be ascertained, about the serious incident and relevant context
- A decision about whether or not an LCSPR should be commissioned using the criteria set out in Working Together 2018
- If the decision is to commission an LCSPR, the key lines of enquiry and the questions that are to be answered by the review process should be set out in the conclusion to the rapid review
- Good practice examples
- Any immediate learning already established and plans for their dissemination

The National Panel has published guidance on undertaking Rapid Reviews, and example Rapid Reviews.

Rapid Review reports will be submitted to:
Mailbox.NationalReviewPanel@education.gov.uk

Where a Rapid Review (or Local Child Safeguarding Practice Review) requires a migration, border or citizenship related contribution from the Home Office, the Immigration Enforcement's National Command and Control Unit (NCCU) should be notified:
NCCU can be contacted 24 hours a day, seven days a week at 03000 134 999 or CommandandControlUnit@homeoffice.gov.uk.

## 6. Safeguarding siblings and/or other children

The rapid review should be assured that any other children within the subject child's network are adequately safeguarded. Where there are concerns about the welfare of siblings or other children, the Pan-Sussex Child Protection Procedures must be followed, including those covering organised and complex abuse if relevant.

## 7. Local Child Safeguarding Practice Reviews (LCSPR)

The primary purpose of a Safeguarding Practice Review is to focus on improving learning, professional practice (collective and individual agency) and outcomes for children. 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.

Each SCP will, via the CRG, commission and oversee Safeguarding Practice Reviews, and agree the methodology to be used for each review, this decision may be influenced by:

- Known areas of improvement needed, including where those improvements have been previously identified,
- Re-occurring themes in safeguarding and promotion of the welfare of children,
- Concerns regarding effectiveness of agencies working together and associated procedures,
- Concern about the actions of a single agency and relevant procedures,
- Where there has been no agency involvement and this gives safeguarding partners cause for concern,
- Where more than one local authority, police area, of CCG is involved, particularly where families have moved around,
- When serious abuse takes place in an institution, or multiple abusers are involved, the same principles of review apply but reviews are likely to be more complex, on a larger scale, and may require more time. The scope of any local child practice review and the methodology needs to be carefully considered to explore the issues relevant to the specific case,

- Recommendation from the National Child Safeguarding Practice Review Panel to undertake a local review.

Any review commissioned should apply the principles of the SCP Learning Improvement Framework; and give regard to the local context, appreciating what works and why, what needs improving and be appropriately curious and challenging. The methodology applied 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 aim to be completed with a published report within 6 months of agreeing to commission a review. This will be dependent on parallel processes, such as criminal proceedings, however sharing the learning from the review will not delayed by this.

The final report should include recommended improvements, and an analysis of any systemic or underlying reasons why actions were taken or not in respect of the matters covered by the report. Safeguarding partners have a responsibility to ensure learning from Child Safeguarding Practice Reviews is embedded.

## 8. Engagement of parents/carers

Children's and family's experience are at the heart of learning, inviting their contribution to reviews is important.

PSSCP supports the principle that parents and carers should be informed when a rapid review or safeguarding practice review is being undertaken. Due to the tight timescales of a rapid review completion (15days) it is not considered timely or practical to contact the family during this period, except in exceptional circumstances. Each CRG should identify this as an action for the rapid review to determine when the family should be contacted, including when the decision not to carry out any further review is taken.

Parents/carers will be supported to understand how they are going to be involved and their expectations will be managed appropriately and sensitively. At the time of a serious incident families are likely to be in contact with multiple agencies and engaging in different processes; this will be particularly so in the case of a child death. Each SCP CRG will be responsible for agreeing if, when and how parents/carers are to be contacted. Best practice is to arrange for someone working closely with the family to personally deliver and explain a notification letter, preferably with the person leading the review. It is not good practice for a letter to be sent 'cold' to family

members unless every reasonable attempt to arrange a face-to-face interview has been exhausted. In such situations the wording of the letter will be carefully considered.

If during the review third parties become known and are considered to offer an important perspective on the case (such as friends or key members of the network of the family), there will be consideration as to how best to invite them to participate in the review by meeting with the reviewer. The means of notifying them of the request should be the subject of careful consideration, informed by their circumstances.
The use of interpreters or translation services will be used where English is not the first language of the family members, including translation of written reports.

When there are pending criminal proceedings involving the parents, family members or other significant adults, the decision about how and when to notify the family will be discussed with a representative of the investigating police force.

## 9. Informing and Supporting staff

Each agency involved with the case must identify which of their staff are involved and provide support, information and updates on any review being undertaken. This relates both to the impact of possible trauma but also in terms of any anxieties or worries about the review. Agencies should also be clear about the purpose of a review and clearly explain this to staff (e.g. not refer to it as an investigation).

Reviews will take a system wide view of what happened and within this, practitioners will be fully involved in reviews and invited to contribute their perspectives, this should be without fear of being blamed for actions they took.

Managers have a duty of care to employees and volunteers and should ensure that whether they are interviewed/attend a practitioner event or not in relation to a case where there is a review, staff involved are supported throughout the process. This might be by the provision of support from the employer or by giving advice about sources of independent support. In addition, or as an alternative, staff may also wish to consult their Trade Union or professional association about sources of support. Managers should not prevent or discourage this.

Where practitioners are called as witness to a parallel process (e.g. coroner's inquest, criminal trial) consideration of when and how to engage the practitioner should taken in consultation with police colleagues. Practitioners will be provided with clarity about what information can be shared for the review.

## 10. Undertaking Local Child Safeguarding Practice Reviews

The purpose of a **local** child safeguarding practice review is to identify any improvements that should be made locally to safeguard and promote the welfare of children (both collectively and individually). Learning must be at the heart of all reviews and should seek to prevent or reduce the risk of recurrence of similar incidents.

The SCP for the area in which the child is normally resident is usually the lead area for a review. Any other partnerships that have an interest or involvement in the case should be invited to be included as partners in jointly planning, undertaking the review and the recommendations for learning and improvement.

The SCP does not have the power to instruct other partnerships to carry out any action (and vice versa) but should ensure the responsibilities are clearly communicated to other partnerships. Where another partnership does not agree with an action or fails to carry it out the CRG should seek clarification of the reasons why and if necessary escalate the issue(s) to the three lead safeguarding partners.

In the case of looked after children, the Local Authority with statutory responsibility for looking after the child should take lead responsibility for conducting the review, again involving other partnerships with an interest or involvement.
Each SCP Partnership Business Team will be responsible for administrative support and co-ordination of reviews.

As highlighted previously each SCP CRG will have responsibility for commissioning and supervising the review including:

- agreeing methodology
- selecting a reviewer
- agreeing organisations and nominations for each SPR review panel
- resolving any issues escalated by the SPR review panel
- supervising progress and timescale of the review (aiming for completion within 6 months of agreeing to commission)
- quality assure the final review report
- submit final report to the area SCP Steering Group/Board

### Notifying Agencies

Once the SCP has decided to carry out a local child safeguarding practice review, a letter of notification will be sent to Statutory Safeguarding Leads and organisations involved in the review. Agencies should notify their respective regulators as required.

### Engagement of agencies and organisations in the review

Each SCP CRG ensures that there is appropriate representation in the review process of professionals and organisations who were involved with the child and family. The priority will be to engage organisations in a way which will ensure that important factors in the case can be identified and appropriate action taken to make improvements.

Each SCP CRG will agree whether an LCSPR review panel should be established for each review. It is recommended that this should be done and that representatives can access their agency information, can make comment and recommendations on behalf of their agency and should not have been operationally involved with the case.

### Notification and Engagement of Families and Practitioners

Those directly impacted by the case should be given opportunity to engage in the review process, and communication with them should be done sensitively and through appropriate methods.

### Selecting methodology

Any review commissioned as a result of a Rapid Review decision will be considered a Local Child Safeguarding Practice Review, this is regardless of the methodology it applies.

The methodology applied should enable further exploration of the key system and practice issues questions identified at rapid review and deepen learning identified by the rapid review. It should also enable the review to be proportionate, timely and support a final report that provides accessible learning.

### Selecting Reviewer

The lead reviewer of an LCSPR will be responsible for facilitating enquiry, reviewing key information and documentation, and engaging with practitioners and families in the review. They should also ensure that professional curiosity and challenge is applied throughout each stage of the review.

PSSCP support utilisation of expertise from within the local partnership network to lead reviews (where capacity allows), and that in all cases the reviewer should:

- Have 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

## 11. LCSPR Report

The final report must be of good quality and include:

a) A summary of recommended improvements for the safeguarding partners or others to safeguard and promote the welfare of children
b) An analysis of the systemic or underlying reasons why actions were taken or not taken in respect of matters covered by the report
c) Examples of good practice
d) Consideration of the lived experience/view of the family/child, including reflection on:
    - What was the child's true lived experience and how can their voice be heard in the review?
    - How was the race, culture, faith, and ethnicity of the child and/or family considered by practitioners and did cultural consideration impact on practice?
    - How did any disability, physical or mental health issues, and any identity factors in the child and/or family impact on the child's lived experience and on practice?
    - Were any recognised risk factors present or absent and did they play a significant part in the child's lived experience?

Final reports will also:

- Be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- Be suitable for publication without needing to be amended or redacted.

Any recommendations which are made must be clear on what is required of relevant parties collectively and individually and focussed on improving outcomes for children. The Statutory Safeguarding Leads for each SCP will approve the final report, along with review by the Independent Scrutineer/chair and Steering Group/Board. Once approved, CRG will:

- Make arrangements to provide feedback and debriefing to family members as appropriate.

- Make arrangements to provide feedback and debriefing to staff as appropriate.
- Make arrangements to provide a briefing to the media as appropriate.
- Draft a partnership response to the review.
- Disseminate the final report and response to relevant interested parties.
- Publish the final LCSPR report and response once the review has been completed and, if required, any relevant parallel proceedings concluded.
- Implement those actions for which the SCP has lead responsibility and monitor the timely implementation of the actions resulting from the review.
- Formally conclude the review process when all the actions have been implemented.
- Undertake a review of the action plan and consider a reflective learning event two years post plan sign off at Steering Group/Board.

## 12. Publication

Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond, therefore SCPs **must** publish the final report, unless it is considered inappropriate to do so. In such a circumstance, the SCP **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. Where it is considered inappropriate to publish locally, the LCSPR should be published anonymously vis the NCPCC national repository.

Reports should be written in such a way that what is published avoids harming the welfare of any children or vulnerable adults involved in the case.

SCP Managers will be responsible for submitting a copy of the full report to the Panel and to the Secretary of State no later than seven working days before the date of publication. Where the safeguarding partners decide only to publish information relating to the improvements to be made following the review, they must also provide a copy of that information to the Panel and the Secretary of State within the same timescale. They should also provide the report, or information about improvements, to Ofsted within the same timescale.

If there are delays in the completion of reviews, the reasons for delay should be shared with the National Review Panel.

## 13. Parallel Processes

LCSPRs should not be delayed as a matter of course because of outstanding family, civil or administrative court cases or coroners' proceedings. The review will consult appropriately when there are any dual court processes, e.g. pending criminal, civil proceedings, and where necessary having obtained legal advice.

Where information shared within the review is requested or needs to be consider by any criminal, civil (incl. family court) or coroner's proceedings, each SCP will obtain legal advice. Where appropriate, each SCP by arrangement will obtain legal advice through the Local Authority Legal Services.

## 14. Media

Any serious child safeguarding incident may attract media attention which each SCP should be alert to. Agency media relations teams should be aware of incidents and where needed prepare a response in case of enquiries.

Prior to publication of a LCSPR the SCP and all relevant partner agencies and organisations should anticipate the likely response from the media and plan in advance how to manage it constructively. A lead agency may take responsibility for de-briefing family members, or for responding to media interest about a case, in liaison with contributing agencies and professionals.

## 15. Learning

Learning to be shared and embedded in line with SCPs learning improvement frameworks, including:

- Publishing the reviews on the local SCP website and NSPCC repository.
- Producing learning briefings for rapid reviews (which do not result in an LCSPR) and for LCSPRs, which are published on the SCP website and disseminated widely. Briefings to include links to further guidance and training and 'learning for practice' questions to be used in team meetings and group supervision. Staff are encouraged to minute these discussions and share with their designated safeguarding leads.
- Holding regular 'learning from safeguarding practice review' events which staff from all agencies are invited to. As well as sharing learning from local LCSPRs, the events also should include learning from reviews nationally.
- Producing learning tools in a variety of formats, such as short presentations and podcasts, available on the SCP website.

- Encouraging agencies to share with the ESSCP how they disseminate the learning from LCSPRs in their organisations.

Reviews for each SCP are published:

- East Sussex Safeguarding Children Partnership Safeguarding Practice Reviews (previously Serious Case Reviews) - ESSCP
- West Sussex Safeguarding Children Partnership West Sussex Serious Case Reviews/Child Safeguarding Practice Reviews and Audits - (westsussexscp.org.uk)
- Brighton & Hove Safeguarding Children Partnership Child Safeguarding Practice Reviews (CSPRs) - BHSCP

## National Reviews

National Child Safeguarding Practice Reviews examine issues that are complex or of national importance. On receipt of the information from the rapid review, the National Panel must decide whether it is appropriate to commission a national review of a case or cases. They must consider the following criteria and guidance:

a) highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
b) raises or may raise issues requiring legislative change or changes to guidance issued under or further to any enactment
c) highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children

## Child Death Review Process

Child Death Review process covers children; a child is defined in the Children Act 1989 as a person under 18 years of age. A child death review must be carried out for all children regardless of the cause of death. This includes the death of any live-born baby where a death certificate has been issued. Strong links between the Safeguarding Children Partnerships and CDOP is maintained via attendance of Local Authority Heads of Safeguarding and Designated Doctor for Safeguarding Children at both review panels.

Joint Agency Response (JAR) criteria is set out in Working Together 2018. A JAR is required if a child's death:

- Is or could be due to external causes

- Is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy/childhood)
- Occurs in custody, or where the child was detained under the Mental Health Act
- Occurs where the initial circumstances raise any suspicions that the death may not have been natural
- Occurs in the case of a stillbirth where no healthcare professional was in attendance.

If the results of any JAR investigations or other child death review processes suggest evidence of abuse or neglect as a possible cause of death, a Serious Incident Notification (see above) should be made to the CRG.

## APPENDICIES

### Appendix A – Example Serious Incident Referral Form

# Serious Incident Referral

## For consideration by the *Insert Local SCP* Case Review Group

Serious Incident Referral form to be completed by the referring worker following a discussion with their line manager or designated safeguarding professional, and where appropriate, the Case Review Subgroup member from their agency.

For agencies without a Case Review Panel representative, cases can be discussed with the Head of Safeguarding for the Local Authority - *INSERT LOCAL CONTACT DETAILS*

This form should be countersigned by the authorising manager/professional and emailed to:
*INSERT LOCAL EMAIL*

**The objective of this form is to convey as much information that is readily available at the time of completion. If information is unavailable do not delay in making this referral.**

| **1. NOTIFIER DETAILS** | | | | |
|---|---|---|---|---|
| **Notifying professional:** | | **Role** (in relation to child)**:** | | |
| **Date of notification:** | | **Contact details:** | | |
| **Who are you submitting this referral on behalf of?** (please tick) | **An agency** | ☐ | **A multi-agency partnership** (e.g. CDOP) | ☐ |
| | Please state: | | Please state: | |
| **Signed:** | | | | |

| **2. CHILD'S DETAILS** | | | |
|---|---|---|---|
| **Child's full name:** | | **Other names used:** | |
| **Child's date of birth:** | | **Date of death/ serious incident:** | |
| **Gender:** | | **Ethnicity:** | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Religion:** | | | | **SEN and/or Disability:** | | | | |
| **Child's home address:** | | | | | | | | |
| **Where does the child live?** (please tick) | Home | ☐ | Local authority care | ☐ | With relatives | ☐ | Other, please state | ☐ |
| **Child's educational establishment/status:** | | | | | | | | |

| **3. PARENTS DETAILS** (and other significant adults) | | | |
|---|---|---|---|
| **Mother's name:** | | **Mother's date of birth:** | |
| **Mother's address** (if different): | | | |
| **Father's name:** | | **Father's date of birth:** | |
| **Father's address** (if different): | | | |
| **Details of any other significant adults and their relationship to the child:** | | | |

| **4. DETAILS OF SIBLINGS** | | | | |
|---|---|---|---|---|
| **Name of sibling:** | **Date of birth:** | **Gender:** | **Address** (if different to key child): | **Educational establishment:** |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| **5. REASON FOR REFERRAL** (please tick all appropriate options) | |
|---|---|
| Considered to meet the criteria for a Child Safeguarding Practice Review (as set out in Working Together to Safeguard Children 2018) | ☐ |
| Child has died and abuse or neglect is known or suspected to be a factor | ☐ |
| Child has been seriously harmed (e.g. a potentially life threatening injury, serious sexual abuse) and abuse or neglect is known or suspected to be a factor | ☐ |
| There are concerns about the way that agencies have worked together to safeguard the child | ☐ |
| The case provides opportunities for learning lessons from multi-agency work | ☐ |
| Child has completed suicide | ☐ |

| | |
|---|---|
| Child has been a perpetrator of a serious crime | ☐ |
| Additional considerations:<br>• There is cause for concern about the actions of a single agency<br>• There has been no agency involvement, and this gives cause for concern<br>• Where more than one local authority, police area or NHS area is involved, including in cases where families have moved around<br>• Where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings<br>• Some cases may not meet the definition of a 'serious child safeguarding case', but nevertheless raise issues of importance to the local area. That might, for example, include where there has been good practice, poor practice or where there have been 'near miss' events | ☐<br>☐<br>☐<br>☐<br>☐ |
| Please outline why the referrer believes this case meets the threshold for a referral to the Case Review Group?<br>Such as, please identify the key moments where different decisions could have been made, where there are gaps in service/support and what learning could potentially be gained from this case/incident: | |
| | |

| **6. CASE OUTLINE** |
|---|
| Please give a brief summary of the events leading to the referral including any critical incidents, key dates, status of child, details of any disability or communication issues and any other relevant information. |
| |

| **7. PARTICULAR CONSIDERATIONS** |
|---|
| Please specify any considerations for this case, for example;<br>Any media interest or criminal considerations or other linked cases.<br>If the case is known to be subject to a criminal investigation please state the lead investigator.<br>If the case is known to be the subject of a Coroner's Enquiry please state key contact. |
| |

| 8. ANY OTHER RELEVANT INFORMATION OR ISSUES |
|---|
| |

| 9. OTHER KNOWN AGENCY INVOLVEMENT | | | |
|---|---|---|---|
| **Agency:** | **Name and role of key worker** (in relation to key child)**:** | **Contact details** | **Reason for involvement:** |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| 10. AUTHORISATION FOR REFERRAL | | | |
|---|---|---|---|
| This form should be countersigned by the manager/professional with whom this referral was discussed. | | | |
| **Name:** | | **Role:** | |
| **Signature:** | | **Date:** | |
| **Contact details:** | | | |

**Appendix B – Rapid Review Information Request Template**

# *Insert Local SCP* Safeguarding Children Partnership

## Rapid Review Information Request

Under arrangements set out in Working Together 2018, when a serious child safeguarding incident occurs, the Local Safeguarding Children Partnership is required to undertake a **'rapid review'**[2]. The findings of the review will be submitted to the National Child Safeguarding Practice Review Panel[3].

**The aim of this 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 to undertake a child safeguarding practice review
- share identified learning appropriately

**Your agency has been identified as being involved with the child/family shown below. For the purposes of the rapid review, it is important that agencies reflect on their involvement when completing this form.**

**Please return the completed form by XX/XX/XXX**
**Forms should be emailed (securely) to: *INSERT LOCAL EMAIL***

[2] **Rapid Reviews** are additional and separate to the Child Death Review/ Joint Agency Review process. The WSSCP is required to submit its findings to the Panel within 15 days of the critical incident

[3] **National Child Safeguarding Practice Review Panel** – is responsible at a national level for identifying and overseeing the review of serious child safeguarding cases which it considers are of national importance, with local safeguarding practice reviews being the responsibility of the West Sussex Safeguarding Children Partnership.

**The information submitted here is confidential and is not for onward circulation.**

| SECTION 1 – YOUR DETAILS | |
|---|---|
| **Your Name and Role** | |
| **Your Agency** | |
| **Contact (email and telephone)** | |

| SECTION 2 – CHILD'S DETAILS | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Child's full name:** | | | | | **Other names used:** | | | |
| **Child's date of birth:** | | | | | **Date of death/ serious incident:** | | | |
| **Gender:** | | | | | **Ethnicity:** | | | |
| **Religion:** | | | | | **SEN and/or Disability:** | | | |
| **Child's home address:** | | | | | | | | |
| **Where does the child live?** | Home | ☐ | Local authority care | ☐ | With relatives | ☐ | Other, please state | ☐ |
| **Child's educational establishment/status:** | | | | | | | | |
| **Period of Interest for the Rapid Review** | **XXXX to XXXX**, but if there is relevant info in advance of this please include, also please include as a summary any relevant info regarding sibling and/or parents. | | | | | | | |

| SECTION 3 – Summary of incident as known |
|---|
| |

| SECTION 4 - Parent/Carer / Family / Significant Others and Household Details | | | |
|---|---|---|---|
| **Mother's name:** | | **Mother's date of birth:** | |
| **Mother's address (if different):** | | | |
| **Father's name:** | | **Father's date of birth:** | |
| **Father's address (if different):** | | | |
| **Details of any other significant adults and their relationship to the child:** | | | |

| DETAILS OF SIBLINGS | | | | |
|---|---|---|---|---|
| **Name of sibling:** | **Date of birth:** | **Gender:** | **Address (if different to key child):** | **Educational establishment:** |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**If your agency holds information different to the above or information on any other family/significant others please provide details here:**

| **Agency details on any significant others** (not included above) | | | | |
|---|---|---|---|---|
| **Name** | **Relationship to child** | **Gender** | **Date of Birth** | **Last known address** |
| | | | | |
| | | | | |
| | | | | |

| SECTION 5 – SAFEGUARDING OTHER CHILDREN |
|---|
| Is there any other child (ren) for which immediate action is needed/taken to ensure their safeguarding needs are met? |
| |

| |
|---|
| |

| SECTION 6 – KEY EVENT SUMMARY OF AGENCY INVOLVEMENT |
|---|
| **Provide a SUMMARY of agency/service involvement - this should include:**<br>• your agency reference number for the child / children / adults (such as NHS number, PNC number, Social Care case number, etc.)<br>• any concerns about the child / children or parents / family members and actions taken by your agency to ensure safeguarding needs have been met<br><br>**Chronology/significant events should be noted in the next section** |
| |

**Provide a SUMMARY of significant events / interventions (e.g. changes in family, coming to the attention of the Police, Attendance at A&E, referral to other agency)**
Please try and restrict submission to two pages – this is a summary of the information you hold on contact with this child. Add more rows as required.

| **Date / Period / Length of involvement** (Chronological Order) | **Type of Involvement / Significant Event** | **Outcome** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Frontline staff involvement during time known to your services within the period of interest specified above**
*** It is the responsibility of each organisation to ensure that staff involved with the case are supported and updated about details of the incident and this review ***

| **Name** | **Job Title** | **Dates of involvement** |
|---|---|---|
| | | |
| | | |
| | | |

| Other agencies / practitioners known to be involved from your records | | |
|---|---|---|
| **Name** | **Job Title** | **Dates of involvement** |
| | | |
| | | |
| | | |

| SECTION 7 – AGENCY REFLECTIONS & LEARNING |
|---|
| **Based on the events and interventions above consider:**<br>1. **Were the needs of the child understood and responded to by the intervention/service provided?**<br>If so, what helped achieve this (e.g., input from child/family, timeliness, relationships, procedure compliance)?<br>If this wasn't achieved, what stopped or limited this? |
| |
| **Based on the events and interventions above consider:**<br>2. **Did your agency/service work with others?**<br>If so what worked well (e.g. shared plans and analysis, good challenge etc)<br>What improvements could be made? |
| |
| **Based on the events and interventions above consider:**<br>3. **Identity and Intersectionality**<br>How was the child's/or family's race, culture, faith, and ethnicity considered by practitioners and did cultural considerations impact on practice?<br>How did any disability, physical or mental health issues, and any identity factors for the child and/or family impact on the child's lived experience and on practice?<br>How were the child's intersecting needs identified and understood? |
| |
| **Based on the events and interventions above consider:**<br>4. **What key moments, if any, can be identified where different decisions could have been made?**<br>What would the potential impact of this have been? |
| |

| |
|---|
| **Based on the events and interventions above consider:**<br>**5. What is the immediate learning identified by your agency and how will this be shared?** |
| |

## Thank you for completing the Rapid Review.

[i] Section 16 of the Children Act 2004, as amended by the Children and Social Work Act 2017, states that the safeguarding partners and relevant agencies for a local authority area in England must have regard to any guidance given by the Secretary of State in connection with their functions under sections 16E-16J of the Act – the relevant statutory guidance for the purpose of safeguarding is Working Together to Safeguard Children (2018).