Hampshire Safeguarding Children Partnership

National & Local
Child Safeguarding Practice Review
Procedure & Guidance

Sections

1 Introduction

1.1 A function of the Hampshire Safeguarding Children Partnership 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 who's permanent residence is within the Local Authority area. This document sets out the arrangements that are in place to respond to these reviews and what happens once a referral is made to the Hampshire Safeguarding Children Partnership under Chapter 4 of Working Together to Safeguard Children (2018). This document also sets out arrangements for the Child Safeguarding Practice Review Panel to undertake reviews at a national level.

1.2 A flowchart (see Appendix A) shows the key processes involved.

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2 Purpose of child safeguarding practice reviews

2.1 The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children.

2.2 Reviews seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account.

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3 Responsibilities

3.1 Hampshire Safeguarding Children Partnership are responsible for overseeing the review of serious child safeguarding cases which, in their view, raise issues of importance in relation to Hampshire.

3.2 **The Child Safeguarding Practice Review Panel**[2] is responsible at a national level for overseeing the review of serious child safeguarding cases which in its view raise issues that are complex or of national importance.

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4 Criteria for Child Safeguarding Practice Review

4.1 'Serious child safeguarding cases' are those in which:

(a) abuse or neglect of a child is known or suspected
(b) the child has died or been seriously harmed

[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

[2] This replaces the Panel of Experts (Working Together 2015,17). The Panel also maintains oversight of the system of national and local reviews and how effectively it is operating.

4.2 The Hampshire Safeguarding Children Partnership may undertake a local child safeguarding practice review in other circumstances. For example, some cases may not meet the definition of a 'serious child safeguarding case', but nevertheless raise issues of importance to the local area. This includes where there has been good practice, poor practice or where there have been 'near miss' events. In such cases, the Learning and Inquiry Group should consider what action to take and how impact and outcomes will be measured and evidenced.

4.3 Meeting the criteria does not mean that Hampshire Safeguarding Children Partnership must automatically carry out a local child safeguarding practice review. Locally it is for the Learning and Inquiry Group, on behalf of the Hampshire Safeguarding Children Partnership, to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice.[3] Read also section 8 for more information on criteria for local reviews.

4.4 Decisions on whether to undertake reviews should be made transparently and the rationale communicated appropriately, including to families.

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5 Duty on Local Authorities to notify incidents to the Child Safeguarding Practice Review Panel

5.1 Where the Hampshire Safeguarding Children Partnership knows or suspects that a child has been abused or neglected, it must notify the Child Safeguarding Practice Review Panel[4]. 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. They should do so within five working days of becoming aware that the incident has occurred.

5.2 The local authority should report the event to the local safeguarding partners[5] and locally to the Hampshire Safeguarding Children Partnership **Independent Chair & Business Manager** within five working days.

5.3 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

5.4 The duty to notify events to the Child Safeguarding Practice Review Panel rests on the local authority.

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6 The Learning and Inquiry Group

5.5 6.1 The Learning and Inquiry Group is a standing Subcommittee of the Hampshire Safeguarding Children Partnership. Any partner agency may refer a case to the Learning and Inquiry Group if they believe that there are important lessons for multi-agency working to be learned from the case.

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[3] Issues might appear to be the same in some child safeguarding cases but reasons for actions and behaviours may be different and so there may be different learning to be gained from similar cases.

[4]. Local authorities should continue to use Ofsted's current online notification system to notify the Panel *until a new system for the Panel goes live later in the year.* Notifications made through this route will go to the Panel, Ofsted and the DfE.

[5] Including, if, for example, the event relates to a looked after child who has been placed out of area.

The Subcommittee has several functions and tasks delegated to it. In summary, the Learning and Inquiry Group will coordinate the following inter-related activity:

- Making recommendations to the Independent Chair as to:
  - whether a child safeguarding practice review should be carried out and the methodology to be used, or
  - whether a child safeguarding practice review should not be carried out but another type of review should be undertaken and the methodology to be used, or
  - whether other action should be taken by the Hampshire Safeguarding Children Partnership.
- Commissioning local child safeguarding practice review , positive learning review or other types of reviews on behalf of the Hampshire Safeguarding Children Partnership.
- Monitoring partner agency and the Hampshire Safeguarding Children Partnership's action plans following the publication of child safeguarding practice reviews or completion of another type of review.
- Using the learning from local and national child safeguarding practice reviews to inform policy, practice and the Hampshire Safeguarding Children Partnership learning and development programme.

6.2 For detailed information about the Learning and Inquiry Group read the Terms of Reference.

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7 Referring cases to the Learning and Inquiry Group for consideration

7.1 Each agency must have arrangements for identifying cases where the agency considers that criteria for either a local or national child safeguarding practice reviews may be met (see sections 4 and 8). It is important that any practitioner or professional is able to discuss a case with their agency Learning and Inquiry Group representative if they think a child safeguarding practice review may be required.

7.2 The Learning and Inquiry Group representative should notify the Hampshire Safeguarding Children Partnership Team of a referral and confirm this in writing within 48 hours using the referral form (see Appendix B).

7.3 The Hampshire Safeguarding Children Partnership Team will request agency information to enable the reports to be available to the Learning and Inquiry Group so that the group can undertake a rapid review of the case (see section 8.2) and make a recommendation to the Independent Chair as to what kind of review should be commissioned, or if no further action should be taken.

7.4 Locally the three safeguarding partners have ultimate responsibility for deciding whether to conduct a local review. The Independent Chair will also be informed to allow independent scrutiny of the decision making process.

7.5 Cases may be referred by the local Child Death Overview Panel. The Chair of the Child Death Overview Panel (CDOP) may refer a case to the Learning and Inquiry Group that appears to meet the criteria and which he or she considers is likely to have important lessons for inter-agency working.

7.6 Section 16K 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

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8 Decision Making

8.1 Criteria

'Serious child safeguarding cases' are those in which:

(a) abuse or neglect of a child is known or suspected
(b) the child has died or been seriously harmed

8.1.1 As well as the criteria defined above the Learning and Inquiry Group, on behalf of the **Hampshire Safeguarding Children Partnership**, must consider:

a) Whether the case highlights or could highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified

b) Whether the case highlights or could highlight recurrent themes in the safeguarding and promotion of the welfare of children

c) Whether the case raises or may raise issues relating to the safeguarding and promotion of the welfare of children in institutional settings[6]

d) Whether the case highlights or could highlight concerns regarding two or more agencies working together effectively to safeguard and promote the welfare of children

e) Whether the case is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate

8.1.2 The Learning and Inquiry Group must also have regard to the following circumstances:

f) where the safeguarding partners have cause for concern about the actions of a single agency

g) where there has been no agency involvement, and this gives the safeguarding partners cause for concern

h) where more than one local authority is involved, including in cases where families have moved around

i) Where a positive outcome for a child has been achieved and learning has been identified.

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[6] "Institutional settings" includes—
(a) all children's homes including secure children's homes;
(b) all custodial settings where a child is held, including police custody, young offender institutions and secure training centres;
(c) all settings where detention of a child takes place including under the Mental Health Act 1983 or the Mental Capacity Act 2005.

8.2 Undertaking a rapid review

8.2.1 On receipt of notification of a serious incident the Hampshire Safeguarding Children Partnership Team will review the timescale until the next Learning and Inquiry Group. If the meeting falls outside of the required 15 working day rapid review response time an extraordinary meeting will be convened to discuss the case. All LIG members would be invited to attend the meeting. For purposes of quoracy Children's Services , Police and Clinical Commissioning Group would be required to be represented for the meeting to be quorate. The rapid review will need to understand both the relevant circumstances and the involvement of local agencies. This should be completed within 15 working days.[7]

8.2.2 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 or not to undertake a child safeguarding practice review

8.2.3 Locally the rapid review takes the form of 'summary of involvement requests' which are sent to all Learning and Inquiry Group members partners for completion by the Hampshire Safeguarding Children Partnership Team. This informs decision making. On completion of the rapid review the Hampshire Safeguarding Children Partnership Team will send a briefing to the three named safeguarding partners and the Hampshire Safeguarding Children Partnership Independent Chair. This will include the reasons for the Subcommittee's view on whether the criteria have been met or not, plus an outline of the methodology for the review (Appendix E- Methodologies menu) (where a local child safeguarding practice review is recommended). Where the child has died, the Learning and Inquiry Group will also use information available from the professionals involved in reviewing the child's death to assist in making this decision (i.e. CDOP minutes and standard reports).

8.2.4 The Hampshire Safeguarding Children Partnership Partners will then inform the Hampshire Safeguarding Children Partnership Team whether a review should be initiated, or not. The Partnership Team will at this stage notify the Child Safeguarding Practice Review Panel. See section 9.4 Notification for next steps.

8.2.5 If during the course of a local child safeguarding practice review, new information comes to light which suggests that a national review may be appropriate the Hampshire Safeguarding Children Partnership Team, after liaising with the Hampshire Safeguarding Children Partnership Independent Chair and Safeguarding Partners, will inform the Panel.

8.2.6 if the recommendation is to undertake a local child safeguarding practice review Whilst the Panel considers the information to advise the LSCP whether they intend to undertake a **national** child safeguarding practice review, the Learning and Inquiry Group should undertake necessary planning for a **local** child safeguarding practice review so that immediate action can be taken once the Panel's views are known.

[7] Edward Timpson's letter states that this should be completed within 15 working days of receiving the notification. Can we update this with the updated guidance from the NP

9 Undertaking Local Child Safeguarding Practice Reviews

9.1 Purpose

9.1.1 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.

9.2 Local review criteria

9.2.1 See criteria on section 8

9.3 Deciding which safeguarding partnership should take lead responsibility

9.3.1 The LSCP for the area in which the child is normally resident decides whether an incident notified to them meets the criteria for a local child practice review.

9.3.2 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.

9.3.3 The Hampshire Safeguarding Children Partnership can not instruct another partnership to carry out a review (and vice versa) but must ensure the responsibilities are clearly communicated to other partnerships.

9.3.4 Where another partnership does not agree with an action or fails to carry it out the Learning and Inquiry Group should seek clarification of the reasons why and if necessary escalate the issues to the Hampshire Safeguarding Children Partnership Independent Chair.

9.3.5 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.

9.4 Notifications

9.4.1 In Hampshire, once the Hampshire Safeguarding Children Partnership Independent Chair has communicated their decision, the Hampshire Safeguarding Children Partnership Team will inform the Panel, Ofsted and DfE[8] of the decision on whether or not the Hampshire Safeguarding Children Partnership are commissioning a local child safeguarding practice review of any notified case, and about their next steps, including the name of any reviewer commissioned. The decision may be subject to scrutiny by the panel.

9.4.2 Once the Hampshire Safeguarding Children Partnership has decided to carry out a local child safeguarding practice review, a letter of notification will be sent to Hampshire Safeguarding Children Partnership members.

[8] Mailbox.NationalReviewPanel@education.gov.uk, 'SCR.SIN@ofsted.gov.uk', 'Mailbox.CPOD@education.gov.uk'

9.4.3 In all cases and at all stages in the local child safeguarding practice review process information relating to children, family members and professionals involved in the case (with the exception of the Hampshire Safeguarding Children Partnership Independent Chair, Partnership Team, Learning and Inquiry Group and Reviewer/s) will be anonymised before being submitted to any external organisation or body.

9.4.4 If the Hampshire Safeguarding Children Partnership has decided to carry out a different type of review the Hampshire Safeguarding Children Partnership Team will notify the relevant agencies.

9.4.5 Decisions on whether to undertake reviews should be made transparently and the rationale communicated appropriately, including to families.

9.5 Safeguarding siblings or other children

9.5.1 When a child dies or is seriously harmed, and abuse or neglect is known or suspected to be a factor, the Learning and Inquiry Group may require information on whether there are other children who are suffering, or likely to suffer, significant harm and who require safeguarding e.g. siblings or other children in a family network, institution or social network (including social media) within which abuse is alleged and what action has been taken to ensure this.

9.5.2 Where there are concerns about the welfare of siblings or other children, the HIPS Child Protection Procedures will be followed, including those covering organised and complex abuse if relevant.

9.6 Appointing & removing reviewers

9.6.1 The Learning and Inquiry Group on behalf of the Hampshire Safeguarding Children Partnership, leads on the commissioning and supervising of reviewers for local reviews.

9.6.2 Reviewers from the Child Safeguarding Practice Review Panel's pool of reviewers can be appointed for local reviews, where available as well as reviewers from Hampshire agencies.

9.6.3 When commissioning a reviewer, the following will be considered:

a) professional knowledge, understanding and practice relevant to local child safeguarding practice reviews, including the ability to engage both with practitioners and children and families
b) knowledge and understanding of research relevant to children's safeguarding issues
c) ability to recognise the complex circumstances in which practitioners work together to safeguard children
d) ability to understand practice from the viewpoint of the individuals, organisations or agencies involved at the time rather than using hindsight
e) ability to communicate findings effectively
f) whether the reviewer is sufficiently independent of the case and its management, and / or has any real or perceived conflict of interest

9.6.4 A decision will be made dependent on the case and type of review as set out in the methodologies menu as to whether an external or internal Independent Reviewer will be commissioned to lead the review.

9.6.5 An External Independent reviewer is one who has not previously worked for any of Hampshire's Partnership agencies within the past five years.

9.6.6 An Internal Independent reviewer is a senior professional who is employed by a Hampshire Partnership agency but has not had direct involvement in the case or any line management responsibility of professionals involved in the case.

9.6.7 The Learning and Inquiry Group Chair and Team will identify suitable candidates, dependent on the needs of each case review. External Reviewers will be asked to supply:

- a Curriculum Vitae; and
- a referee who will be a Senior Manager or partnership Chair in an authority where they have previously been a reviewer.

9.6.8 Once an External reviewer has been identified a commissioning letter and contract outlining terms and conditions for the case review will be drawn up by the Hampshire Safeguarding Children Partnership Team. The contract will include details of the time allocated, costs agreed, timescales for completion and the format of the Final Report.

9.6.9 The Lead Reviewer is likely to be commissioned to produce the report. However, this needs to be confirmed on a case by case basis.

9.6.10 The Learning and Inquiry Group on behalf of the Hampshire Safeguarding Children Partnership may remove a reviewer from a review at any time prior to the report of the review, or any information relating to improvements, being published.

9.7 Determining the methodology for a review

9.7.1 The Learning and Inquiry Group will agree with the reviewer(s) the method by which the review should be conducted.

9.7.2 The methodology will be consistent with the principles in Chapter 4 Working Together 2018, and the systems methodology recommended by the Munro review[9].

9.7.3 The methodology will provide a way of looking at and analysing front line practice as well as organisational structures and learning. The methodology must reach recommendations that will improve outcomes for children.

9.7.4 The initial scoping of the review will take into account the current information known in each case and identify those who should contribute. As further information becomes available other contributors may be needed.

9.7.5 The Hampshire Safeguarding Children Partnership may have specific questions that should be answered as part of the review. These may link to previous lessons learnt through monitoring and evaluation (e.g. through multi agency case audits or from previous review).

9.8 Engagement of organisations

9.8.1 The Learning and Inquiry Group will ensure that there is appropriate representation in the review process of professionals and organisations who were involved with the child and family.

[9] The Munro Review of Child Protection: Final Report: A Child Centred System (May 2011)

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.

9.8.2 The Hampshire Safeguarding Children Partnership notes the guidance issued by the President of the Family Division on Judicial Cooperation with reviews, which advises that the judiciary do not need to participate in the process. We understand that the judiciary takes this stance, not to evade scrutiny or accountability, but in order to protect its independence and the independence of individual judges. However, where relevant, the Hampshire Safeguarding Children Partnership will share final reports, and the findings from these reviews, with the President of the Family Division in the understanding that he will disseminate these to the wider judiciary.

9.8.3 Consideration needs to be given to the impact of the review on parallel processes. Practitioners may be witnesses in criminal proceedings, therefore discussion with the senior investigating officer needs to take place prior to frontline staff being engaged in the process.

9.9 Engaging Family Members

9.9.1 As part of our duty to ensure that the review is of satisfactory quality and that children and families experiences are at the heart of learning, the Hampshire Safeguarding Children Partnership will always, where possible, seek to ensure that families, including surviving children, are invited to contribute to reviews. They will be supported to understand how they are going to be involved and their expectations will be managed appropriately and sensitively.

9.9.2 Effective communication at an early stage is vital in gaining cooperation from family members during the review process (e.g. interviews). The use of interpreters or translation services will be used where English is not the first language of the family members. Locally best practice is to arrange for someone working closely with the family to personally deliver and explain a notification letter. 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.

9.9.3 The timings of such notifications are crucial, particularly when there are current Police investigations. When there are pending criminal proceedings involving the parents and or family members, the decision about how and when to notify the family will be discussed with a Police representative. See section 13 for information on parallel processes.

9.9.4 When appropriate the family will be invited to share their views with the reviewer or representative from the HSCP.

9.9.5 If during the review third parties whom it is considered can 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.

9.10 Involving & Supporting Practitioners

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

9.10.2 The death or serious injury of a child may be a traumatic event for involved staff (including unpaid staff such as volunteers), particularly if they were involved in service delivery to the child or to the child's family.

9.10.3 Managers have a duty of care to employees and volunteers and should ensure that whether they are interviewed or not in relation to a case where there is a review, staff involved are supported through the process. This might be by the provision of support from the employer or by giving advice about sources of independent support.

9.10.4 Managers should advise staff about access to support through the employing agency (e.g. many organisations have employee welfare services for example which may be able to assist).

9.10.5 In addition, or as an alternative, staff may also wish to consult their Trades Union or professional association about sources of support. Managers should not prevent or discourage this.

9.10.6 The Hampshire Safeguarding Children Partnership has produced e-learning to provide guidance for all staff involved in a Local Learning Review/ Other type of review.

9.11 Supervising the Review

9.11.1 The Learning and Inquiry Group will oversee the review to ensure that the reviewer is making satisfactory progress. This will be actively monitored against the timescales as set out in the contract agreed with the reviewer. Where there are other proceedings which run parallel to a local review the Learning and Inquiry Group will ensure the reviewer works closely with those responsible to avoid one process jeopardising or unnecessarily delaying the other.

9.12 Form and content of final report

9.12.1 The final report must be of satisfactory quality and include:

a) A summary of recommended improvements for the safeguarding partners or other 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

9.12.2 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.

9.12.3 Any recommendations which are made will be clear on what is required of relevant parties collectively and individually and focussed on improving outcomes for children.

9.12.4 The final report must be completed within six months.

9.14 Action on receiving the final report

9.14.1 The Learning and Inquiry Group, on behalf of the Hampshire Safeguarding Children Partnership, will quality assure the final report.

9.14.2 The Hampshire Safeguarding Children Partnership will oversee the process of agreeing with all partners what action they need to take in light of the review's findings.

9.14.3 The Hampshire Safeguarding Children Partnership will approve the final report and via the Learning and Inquiry Group:

- 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 response to the review which outlines actions which have already been taken in response to the review findings; the impact these actions have had on improving services; and what more will be done.
- Disseminate the final report and response to relevant interested parties;
- If a local child safeguarding practice review, publish the final report and response once the review has been completed
- Implement those actions for which the Hampshire Safeguarding Children Partnership 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.

9.14.4 In a **local** child safeguarding practice review, prior to publication the Hampshire Safeguarding Children Partnership and all relevant partner agencies 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.

9.15 Publication of the final report

9.15.1 Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond, so Hampshire Safeguarding Children Partnership will publish the report, unless there are exceptional circumstances where it would be inappropriate to do so. In such a circumstance, Hampshire Safeguarding Children Partnership 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.

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

9.15.3 The Hampshire Safeguarding Children Partnership Team will send a copy of the full report to the Child Safeguarding Practice Review Panel and to the Secretary of State no later than seven working days (a) after completion or (b) before publication, whichever is the sooner. They will

confirm what is being published and when and set out for the Panel and the Secretary of State the justification for any non-publication, or delay to publication, if applicable.

9.15.4 The Hampshire Safeguarding Children Partnership must have regard to any comments the Panel or the Secretary of State have with regard to publication.

9.16 Timescales for review

9.16.1 Depending on the nature and complexity of the case, reports should be completed and published within six months from the date of the decision to initiate a review.

9.16.2 If the Hampshire Safeguarding Children Partnership 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. Hampshire Safeguarding Children Partnership will also provide the report, or information about improvements, to Ofsted within the same timescale.

9.16.3 Where other proceedings may have an impact on or delay publication, e.g. an ongoing criminal investigation, inquest or future prosecution, the Hampshire Safeguarding Children Partnership Team will inform the Child Safeguarding Practice Review Panel and the Secretary of State of the reasons for the delay.

9.16.4 Locally, cases that **do not** met the local child safeguarding practice review criteria may not result in a report which is published. This is decided on a case by case basis. A synopsis of learning will be drafted, and this will be readily accessible on the Hampshire Safeguarding Children Partnership website and proactively distributed to staff, including via Hampshire Safeguarding Children Partnership training and communications.

9.16.5 The Data Protection Act 2018 will be complied with, including when compiling or publishing the report, and Hampshire Safeguarding Children Partnership will comply also with any other restrictions on publication of information, such as court orders which restrict published material about the family. Where a report has been provided to the coroner's inquest prior to publication it should be noted that the inquest is held in public, and therefore there will be scope for reporting of the report in so far as it is made public during the inquest.

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10 National Child Safeguarding Practice Reviews

10.1 Purpose

10.1.1 These are serious child safeguarding cases which examine issues that are complex or of national importance.

10.2 Criteria for a national review

10.2.1 On receipt of the information from the rapid review (see section 8.2.), the 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

10.2.2 The Panel should also have regard to the following circumstances:

a) significant harm or death to a child educated otherwise than at school

b) where a child is seriously harmed or dies while in the care of a local authority, or while on (or recently removed from) a child protection plan

c) cases which involve a range of types of abuse[10]

d) where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings[11]

10.2.3 As well as considering notifications from local authorities and information from rapid reviews and local child safeguarding practice reviews, the Panel also take into account a range of other evidence, including inspection reports and other reports and research. The Panel may also take into account any other criteria they consider appropriate to identify whether a serious child safeguarding case raises issues which are complex or of national importance.

10.3 Notifications

10.3.1 The Panel will inform the Hampshire Safeguarding Children Partnership promptly (usually within 15 working days) following receipt of the rapid review, if they consider that:

- a national review is appropriate, setting out the rationale for their decision and next steps[12]

- further information is required to support the Panel's decision-making (including whether the safeguarding partners have taken a decision as to whether to commission a local review)

10.4 Appointing & removing reviewers

10.4.1 The Panel have a pool of potential reviewers who can undertake national reviews.[13] If they consider that there are no potential reviewers in the pool with availability or suitable experience

[10] For example, trafficking for the purposes of child sexual exploitation

[11] 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

[12] If the Panel decides to undertake a national review they will discuss with the Hampshire Safeguarding Children Partnership the potential scope and methodology of the review and how they will engage with the Hampshire Safeguarding Children Partnership and those involved in the case

[13] A list is publicly available.

to undertake the review, they may select a person who is not in the pool. When selecting a reviewer, the Panel consider whether they have any conflict of interest which could restrict their ability, or perceived ability, to identify improvements impartially.

10.4.2 The Panel may remove a reviewer from the pool at any time. This can be following the appointment, but prior to a report or information to improvements, being published. The Secretary of State must remove the reviewer from the review. Where the Secretary of State removes a reviewer, the Panel must consider appointing another reviewer.

10.5 Determining the methodology for a review

10.5.1 The methodology will be consistent with the principles in Chapter 4 Working Together 2018, and the systems methodology recommended by the Munro review.

10.6 Engagement in and supervision of the review

10.6.1 For national child safeguarding practice reviews, the Panel will follow the same guidance on procedure and supervision as for local child safeguarding practice reviews.

10.7 Expectations for the final report

10.7.1 The Panel will ensure that the final report includes:

- a summary of any improvements being recommended to the safeguarding partners and/or others to safeguard and promote the welfare of children

- an analysis of any systemic or underlying reasons why actions were taken or not taken in respect of matters covered by the report

10.8 Publication of the final report

10.8.1 The Panel will 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.

10.8.2 The Panel will work with safeguarding partners to identify and manage the impact of the publication on children, family members, practitioners and others closely affected by the case.

10.8.3 Reports or information published by the Panel will be publicly available for at least three years.

10.8.4 The Panel will also send a copy of the report or improvements to the Hampshire Safeguarding Children Partnership, Ofsted, the Care Quality Commission and Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services.

10.8.5 The Panel will send copies of published reports of national and local child safeguarding practice reviews, or published information relating to improvements that should be made following those reviews, to the What Works Centre for Children's Social Care and relevant inspectorates, bodies or individuals as they see fit. Where a local review results in findings which are of national

importance, or in recommendations for national government, the Panel should consider the potential of those recommendations to improve systems to safeguard and promote the welfare of children and how best to disseminate and embed such learning.

10.9 Timescales

10.9.1 The Panel will send a copy of the full report to the Secretary of State no later than seven working days before the date of publication. Where the Panel decides 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 Secretary of State within the same timescale.

10.9.2 Reports should be completed and published within six months of the date of the decision to initiate a review. Where other proceedings may have an impact on or delay publication, for example an ongoing criminal investigation, inquest or future prosecution, the Panel will advise the Secretary of State of the reasons for the delay.

10.9.3 The Panel will also set out for the Secretary of State the explanation for any decision not to publish either the full report or information relating to improvements. During the review, the Panel will share any points that arise about improvements needed with the Hampshire Safeguarding Children Partnership in any local authority areas covered by the review and others as applicable.

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11 Auditing and Monitoring: Response to national and local reviews

11.1 The Learning and Inquiry Group will take account of the findings from both local reviews and national reviews, with a view to considering how identified improvements should be implemented locally, including the way in which agencies work together to safeguard and promote the welfare of children.

11.2 Locally, improvement is sustained through regular monitoring and follow up of actions so that the findings from these reviews make a real impact on improving outcomes for children.

11.3 Monitoring of the actions produced from the final report will be undertaken by the Learning and Inquiry Group reporting back to the Hampshire Safeguarding Children Partnership on a regular basis. Upon completion, the Learning and Inquiry Group will advise the Hampshire Safeguarding Children Partnership that all actions are complete.

11.4 Any areas of inter-agency activity identified as of particular concern may also be referred to other Hampshire Safeguarding Children Partnership subgroups for action.

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12 Reviewing Institutional Abuse

12.1 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.

12.2 If, for example, children had been abused in a residential school, it would be important to explore whether and how the school had taken steps to create a safe environment for children, and to respond to specific concerns raised.

12.3 The Learning and Inquiry Group will seek clarity over the interface between the different processes of investigation (including criminal investigations); case-management, including help for abused children and immediate measures to ensure that other children are safe; and review (i.e. learning lessons from the case to reduce the chance of such events happening again). The three different processes should inform each other. Any proposals for review should be agreed with those leading criminal investigations, to make sure that they do not prejudice possible criminal proceedings.

13 Parallel Processes

13.1 There will be instances where a local review has been carried out which could then form part of a thematic review that the Panel undertakes at a later date. There may also be instances when a local review has not been carried out but where the Panel considers that the case could be helpful to a national review at some stage in the future. In such circumstances, the Panel should engage with the Hampshire Safeguarding Children Partnership to agree the conduct of the review.

13.2 The National Panel have their own processes for how they will work with other investigations.

13.3 Locally, if another type of review, for example a Domestic Homicide Review, MAPPA or Safeguarding Adults Review, is being carried out, Hampshire Safeguarding Children Partnership will work collaboratively with those responsible for carrying out those reviews. This is to minimise duplication of effort, uncertainty and/or confusion relating to the different review processes and reduce burdens on and anxiety for the families and children concerned.

13.4 In some cases, criminal proceedings may follow the death or serious injury of a child. The Hampshire Safeguarding Children Partnership Team will discuss with the relevant criminal justice agencies such as the police and the Criminal Prosecution Service, at an early stage, how the local child safeguarding practice review process should take account of such proceedings. Additional information on managing these circumstances can be found in the Liaison and information exchange when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews guidance.

13.5 Where a child has died it may well be the case that their death will be the subject of an inquest conducted by the coroner. The function of the inquest will be to establish the circumstances and cause of the death. Consideration will be given on a case by case basis as to the degree to which any local child safeguarding practice review needs to be informed by the inquest, and vice versa, and this will have implications for the timescales of any review. In any such event the police panel member will inform the Coroner that a Child Safeguarding Practice Review is being undertaken.

13.6 The police panel member on the Child Safeguarding Practice will consider at an early stage the degree to which it will be necessary in the circumstances of the case for the local child safeguarding practice review to have access to information which may emerge from the enquiries of the coroner, and the subsequent inquest. The coroner will also wish to consider the extent to which it will be necessary to receive relevant information from the review, or even

whether or not the inquest can proceed prior to the review concluding. These are issues which should be considered with the benefit of legal advice by the reviewer/s, the Learning and Inquiry Group and the Hampshire Safeguarding Children Partnership Chair, and then raised with the coroner on behalf of the Hampshire at the first pre inquest review hearing.

13.7 Staff involved in any local review should be informed that there is legal precedent for the coroner asking to see the material obtained during any review process, and that therefore it is possible that information shared during the local child safeguarding practice review will be shared with the coroner, who can then decide to disclose any part of the information obtained in the inquest with any interested party to the inquest, including the family. Where agencies participating in the review are also made interested parties to the inquest, it will be possible for staff to seek their own legal advice about this, and if necessary their agency can make its own representations to the coroner. Where possible family members should be met with and made aware of reviews findings prior to receiving any review documents via the coroner's court.

13.8 In the event that there are proceedings which have been or are being conducted in the family court at the time of the review, the Children's Services representative will be requested to consider whether there is any relevant information pertinent to the terms of the review obtained within the family proceedings. If this is the case the Children's Services representation should advise whether whether or not an application to the family court is needed for disclosure of the identified material to the review team.

13.9 Local child safeguarding practice reviews 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.

13.10 The final report will take full account of salient, new information which becomes available during the course of these and any civil or criminal proceedings, and the facts, conclusions and recommendations should be revised accordingly.

Appendix A – Local child safeguarding practice review Flowchart

Practitioner identifies case that they believe meets the criteria as set out in Working Together 2018.

Discuss with Senior Manager and Learning and Inquiry Group (LIG) Representative.

STAGE 1: NOTIFICATION AND CONSIDERATION

Referral to LIG

1. Complete referral form and submit to HSCP Team. Children's Services to establish if the case meets the criteria for a Serious Incident Notification (SIN).
2. HSCP Team and referrer initial discussion if required.
3. If the criteria for a SIN is met, a Rapid Review will be initiated. HSCP Team to discuss review date with LIG Chair to decide if an additional meeting is required to meet statutory timescales.
4. Scoping template sent out to agencies by HSCP Team.
5. Agencies to submit scoping form to HSCP Team within required timescales.
6. HSCP Team to circulate papers to LIG one week prior to meeting.

LIG Meeting

7. Agency LIG Representative presents case.
8. Information reviewed.
9. If a review is agreed;
    a. Terms of Reference drafted
    b. Type of review agreed from Methodology Menu
    c. Identification of an internal reviewer if required

Decision to Commission a Review

10. Rapid Review form completed, including decision on whether a review will be undertaken, and sent to National Panel and HSCP Independent Chair.
11. Notification to HSCP Members and agencies.

STAGE 2: REVIEW
Child Safeguarding Practice Review, Multi-Agency Case Review, other Review or no further action.

Review Commissioned

12. Independent Reviewer formally commissioned.
13. Agency report authors identified.
14. Panel members identified.
15. Family involvement considered.

Review Undertaken

16. Information gathered (dependent on Methodology).
17. Engagement with family and practitioners (dependent on Methodology).
18. Oversight of the review process by the LIG via updates as standing items on LIG meeting agenda.
19. Early draft report to be shared with the LIG chair and senior managers from partner agencies as appropriate.

Outcomes

20. Final report produced with findings and recommendations.
21. Multi-agency and single agency action plans produced.
22. Communication and media strategy agreed.
23. Final report to be present to the LIG by the report author before being sent to the Main Board for ratification. This is the opportunity for LIG members to raise any concerns/issues they have with the final report or its recommendations.
24. Board response produced.
25. Final report taken to the Main Board for ratification. This is the opportunity for Board members to raise any concerns/issues they have with the final report or its recommendations.
26. Outcomes shared with the family and child/children and feedback to practitioners involved in the process.
27. For Child Safeguarding Practice Review's – Final copy of the report sent to the National Panel and Ofsted at least one week prior to publication.
28. Child Safeguarding Practice Review's Publication and report sent to National Repository.

STAGE 3: LEARNING & IMPROVEMENT

Embedding Learning

29. HSCP and partner agencies progress action plans.
30. Key messages are communicated as outlined in the communication strategy.
31. Key messages feed into single agency training.
32. Key messages fed into Learning Workshops.
33. Key messages, where appropriate, fed into HSCP Multi-Agency training plan.

Evaluation

34. LIG oversees progress against Multi-Agency action plans and ensures learning is embedded in practice.
35. Evaluation of Learning Workshops by Workforce Development Group.

Appendix B – HSCB LIG Referral Form

Referral Form

1a. Child's Details			
Child's First Name		Child's Last Name	
Any known aliases		Ethnicity	
D.O.B		Gender	Male / Female
D.O.D (if applicable)		NHS Number	
		Education Setting	
Address			

1b. Family Member Details	Name	DOB
Parents'/Carers' *Please include any known aliases*		
Siblings		

2. This case is being referred;	
To undertake a Rapid Review	
For a Local Learning Review	
For a Single Agency Review	
As a case for discussion	
For a Positive Case Review	

3. Referral Details	
Date of referral	
Name of referrer	
Agency	
Tel. No.	
Email	

4. Agencies known to be involved with the case (please tick)			
Children's Services		NPS	
Police		Probation CRC	
Health Services		YOT	
Education		Housing	
CAMHS		Voluntary Sector	
Out of area services			
Others (*please specify*)			
Out of area organisation			

5. Reason for notification (more than one box may be ticked)	
Abuse or neglect of a child is known or suspected, and the case gives cause for concern as to the way in which the local authority, their Board partners or other	

relevant persons have worked together to safeguard the child.	
A child has died (including suicide)	
A child has been seriously harmed	
There is a concern about the way multi agency partners have worked together to safeguarding the child / children	
Other reason: *(please specify)*	

6. Characteristics of Case					
Domestic abuse		Alcohol abuse		Substance abuse	
Parental mental health		Fabricated or induced illness		Abusive head trauma	
Sexual abuse		Child in care		More than one child abused	
Child of teenage pregnancy		Parent is care leaver		Homelessness/ housing issues	
Emotional abuse		Recent neglect		Long standing neglect	
Physical abuse		Non-Accidental Injury		Overlaying	
Complex family		Hidden adults		Exploitation (including CSE, criminal, county lines, modern slavery)	
Disability- parent/ carer		Serious illness/ chronic condition- parent/ carer		Learning difficulties- parent/carer	
Disability- Child		Serious illness/ chronic condition- Child		Learning difficulties- Child	
Child mental health including self-harm and suicide		Disguised compliance		Non-engagement	
Cross border issues		Radicalisation		Other- *Please specify*	

Is the child subject to a child protection plan?	Yes		No		Previously		Don't know	
Are any siblings on a child protection plan?	Yes		No		Previously		Don't know	
Is there a criminal investigation taking place?	Yes		No		Possible			
Has there been a conviction?	Yes		No		Don't know			

6. Case Outline
Please give a summary of the circumstances of this case and explain why you feel this case should be considered:

(Please continue on a separate sheet if necessary)

7. Case Summary Analysis

Please provide a case summary analysis:

(Please continue on a separate sheet if necessary)

8. Identification of practice strengths and challenges

Please provide a summary of identified strengths and challenges in this case:

(Please continue on a separate sheet if necessary)

PLEASE RETURN THIS COMPLETED FORM SECURELY TO:

HSCP Team:
hscp@hants.gov.uk *(If using Mimecast)*
Hcc.4lscbcdop@nhs.net *(If sending from a secure email address)*

For Office Use:	
Date referral received by HSCP Team	
Date case discussed at Learning and Inquiry Group	
Recommendation to be made by Learning and Inquiry Group to Independent Chair of Hampshire Safeguarding Children Partnership	
This case fits the criteria within Working Together 2018 and should be considered for a local safeguarding practice review	
This case does not meet the criteria within Working Together 2018 and should not be considered for a review	
This case does not fit the criteria within Working Together 2018 for a local safeguarding practice review, however we recommend that a single agency review / other action should be taken	
This case should be considered for a positive learning review	
Chair of Learning and Inquiry Group: Signed……	Date……

Appendix C – HSCP LIG Referral Response Form

Referral Response Form

Name(s) of the subject child(ren):	

Agency Details
Name of person completing report:
Organisation:
Name of LIG representative:

Please explain why you feel this case should be considered for a Local Safeguarding Practice Review. The headings below reflect the criteria for a Local Safeguarding Practice Review as set out in Working Together (2018):
A child has died or has been seriously harmed **Abuse or neglect of a child is known or suspected** **There is cause for concern as to the way the authority, Board partners or other persons have worked together to safeguard the child**

If this case does not meet the criteria for a Local Safeguarding Practice Review, please explain why you feel it should be discussed at the LIG:

Was the child(ren)/ family/ other named persons known to your agency?	**Yes**	**No**

Were any of the named persons known to your agency under another name/ spelling or with a different DOB or address (if yes please detail below):

If not known to your agency please submit to HSCP at this stage
If known to your agency please complete the rest of this form

Name(s) of person known to your service (if more than one person please add rows as required):
Any additional adults or children known to your service
Reason for involvement with that person:

Background summary of involvement (please provide a brief narrative):

Was your agency aware of any previous safeguarding/ child protection issues (if yes please summarise):

Was your agency aware of any other organisations working with the named persons (if yes please list below):

Does your agency have any concerns regarding the way agencies worked together in this case (if yes please detail below):

Has your agency undertaken any form of internal review relating to this unexpected death? If so, please detail:

Please provide a case summary analysis:

Identification of practice strengths and challenges:

Does your agency have any concerns or observations on the following areas in relation to this case:
1. **Issues regarding policies / procedures** 2. **Issues regarding professional practice** 3. **Have you identified any lessons that could be learnt by your agency from this initial scoping? If so, please list them.** 4. **Are there any gaps in your agency's understanding of safeguarding that would prevent your staff learning these lessons?** 5. **Are there any training needs in relation to safeguarding which your agency is unable to meet?**

PLEASE RETURN THIS COMPLETED FORM SECURELY TO:
HSCP Team:

hscp@hants.gov.uk *(If using Mimecast)*
Hcc.4lscbcdop@nhs.net *(If sending from a secure email address)*

Appendix D – HSCB LIG Rapid Review Form

Submitted by Hampshire Safeguarding Children Partnership	
Contact Details:	hscb@hants.gov.uk 01962 876 355
Date of notification to HSCB:	
Date of Rapid Review:	
Date of sign off by LIG chair:	
Date of sign off by HSCB chair:	
Date of submission to the National Panel:	

1. Referral Type	
Does this case meet the criteria for Rapid Review?	Yes / No
Notification of Serious Incident Reference:	
Incident notified to other professional bodies including:	

2. Incident that lead to referral

3. Immediate Safeguarding of other children

4. Background information

5. Initial learning and action taken to respond to this

6. Particular considerations

Please specify any considerations for this case, for example; Is there media interest? Are there crimir proceedings? Is the case linked to a complex abuse case?

7. Recommendation	
This case does not meet the criteria of a Serious Case Review or other type of review.	
Serious Child Safeguarding Case (national review)	
Non Statutory Local Learning Review	
Partnership review	
Table top workshop	
Single agency review/ health review	

8. Rational for decision

9. Present for discussion			
Children's Services		Southern Health	
Police		Southampton Hospital	
CCG- Designated Nurse/Doctor		CAMHS	
YOT		District Council	
Education		CRC	
Hampshire Hospitals		NPS	
Portsmouth Hospital		CAFCASS	
Frimley Park Hospital		SCAS	
Other			

10. Submission of reports			
Children's Services		Southern Health	
Police		Southampton Hospital	
CCG- Designated Nurse/Doctor		CAMHS	
YOT		District Council	
Education		CRC	
Hampshire Hospitals		NPS	
Portsmouth Hospital		CAFCASS	
Frimley Park Hospital		SCAS	
Other			

Appendix E – HSCB LIG Methodologies Menu

Methodologies Menu for reviews – Post Transition

Post transition there is no differentiation between statutory and non-statutory reviews. There is flexibility in what approach and methodology is used, what process is followed and who leads the review of the case. All types of reviews are classed as either Local or National Learning Reviews and the expectation is that all are published.

The following suggested approaches can be considered when commissioning a Local Learning Review:

- **Level one- Single agency review/ health review**

Individual agency will undertake a review into the case to be agreed/ signed off through existing management procedures. In the case of a health review this will be led by the CCG. Findings from the review will be shared with the LIG. Suggest that as this option only includes one agency it would not formally come under the banner of a Local Learning Review and may not need to be published.

- **Level two- Table top workshop**

Practitioners involved in the case are identified by LIG members and attend a half day table top review led by a senior manager independent of line management of the case. Lead to be identified by LIG. A learning summary is produced as a result of the workshop findings and presented to the LIG / Board ahead of publication.

- **Level three- Partnership review**

This is a more detailed review than level two. LIG Scoping forms are used to identify additional areas for further information. As required practitioners may be met individually or as part of a workshop. The Partnership Review will be led by a senior manager from existing agencies. They need to be independent of involvement and / or line management staff involved in the case. Lead to be identified by LIG. A report is produced and presented to the LIG / Board ahead of publication.

- **Level four- Local Learning Review. Can be led by senior staff within LSCB Agencies or an Independent Reviewer**

Agencies involved in the case will be asked to produce a chronology and/ or narrative of the case. A reviewer will be identified either from within the LSCB's member agencies (but who is independent of the case / staff involved in the case), or an externally commissioned Independent Reviewer. A panel will be established consisting of Health, Children's Services, Police and any identified specialist agencies as required. Meetings will be held with practitioners as required and a multi-agency workshop held. A final report will be drafted for publication.

- **Level five- Serious Child Safeguarding Case (national review)**

To be completed once national guidance is available.

Appendix F – Useful Links

Working Together 2018

Child safeguarding practice review panel: practice guidance