



Kirklees Safeguarding Children Partnership



Local Child Safeguarding Practice Reviews Framework 2020

Contents

Version Control: 2

Review Date: 24/04/2019

Introduction	3
Drivers For Change	3
Key Principles	3
Process	4
Serious Child Safeguarding Case notification Notification	4
Pathways	4
Information Gathering	5
Preparation for the Local Child Safeguarding Practice Review Panel Panel and	5
Decision	6
Other Types of Review	7
Terms of Reference for the Review Rapid Review	7
Chronologies	7
Independent Author (Reviewer)	8
Local Child Safeguarding Practice Learning Event Family	8
Involvement	9
Draft Report	10
Concurrent Criminal / Coroners investigations	10
Independent Chair, Chair of LCSPR Sub-Group and KSCP Review Co-ordinator approval	10
LCSPR Sub-Group Approval	11
Business Group Approval Action Plans	11
Firmly fixing lessons into practice	11
Notification to involved Practitioners, Family members, Safeguarding Partnership, [National] Children’s Safeguarding Practice	12
Review Panel and Sec. of State	12
Media	13
Strategy	13
Publication	13

Introduction

This new process represents a significant change from previously used processes for undertaking reviews, this is in large part due to the changes in Working Together 2018 and will require a shift in culture that looks at reviews as rapid investigations rather than long, drawn out processes over a period of a year or more. Kirklees Safeguarding Children Partnership (KSCP) sees changes set out in Working Together 2018 as an opportunity to address some long standing issues with the review process. This guidance sets out how we will meet our statutory obligations and improve the quality and timeliness of our reviews at every stage. The process re-focuses those involved on learning and real change to practice. It recognises that for the learning to be meaningful it must be gained and shared quickly. To accompany the new process over 20 accompanying documents have been revised and accompanying briefings for senior staff who will be key in running this process will be arranged.

The new process has been trialled with three reviews, this version of the guidance reflects an evaluation of those trials and amendments to the process as required.

“Recent research commissioned by the DfE suggests how our learning from terrible events might be better facilitated. It includes greater participation by practitioners, a less costly and lengthy review process and emphasis on reflection and understanding rather than assuming

KSCP intend to share this framework with other West Yorkshire Safeguarding Children Partnerships to support changes they will also need to make to comply with Working Together 2018. It is hoped that they will adopt this process to ensure a clarity across agencies that span more than one local authority and also to potentially share local reviewers to ensure a greater degree of independence work has begun with West Yorkshire partners.

Drivers for Change

The new Working Together 2018 sets out a new approach, criteria and timescales for conducting reviews into the deaths or serious injuries of children as a result of abuse or neglect, coupled with the changes to the structure of LSCP's and longstanding issues with local reviews including:

- length of time from incident to publication
- action plans which are difficult to achieve
- variable quality of review authors
- lack of meaningful change to practice as a result of the review
- low levels of agency attendance at key decision making meetings
- lack of monitoring regarding whether lessons have been truly learnt and fixed into practice

It is therefore imperative that the whole process for reviews is revised.

Key Principles

Safeguarding Practice Reviews are not about apportioning blame and need to consider the context in which practitioners are operating both locally and nationally as well as individual decisions or actions taken or not taken. The purpose of these practice reviews at both local and national level is to learn lessons that can improve the response to children and families.

In order to be effective the review must be completed quickly and efficiently, it will need to take into account the perspectives of those working directly with the family as well as a local strategic view. Findings must be clear and e-learning must be quickly responded to. Actions must be reviewed to ensure they have been embedded and are having their intended improving effect on the issue identified in the review. Where larger, systemic issues are identified these should go to the Safeguarding Children Partnership for consideration about commissioning further work.

Challenge, reflection and analysis are important so that lessons can be learnt and services improved to reduce the risk of future harm to children and to improve their outcomes. Whilst agencies will be dealt with sensitively and respectfully throughout the review process, defensiveness at a level that hinders honest appraisal of the incident and real progress being made in safeguarding practice.

Process

Serious Child Safeguarding Case notification

“Serious Child Safeguarding Cases are those in which:

Abuse or neglect of a child is known or suspected [AND]

The child has died or been seriously harmed

‘Serious harm’ includes serious or long-term impairment of mental health or intellectual, emotional, social or behavioural development. It should also cover instances of impairment of physical health. This is not an exhaustive list and when making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain.”

The duty to notify the (National) Children’s Safeguarding Practice Review Panel rests with the Local Authority through Children’s Social Care as per 16C(1) of the Children Act 2004

Notification Stage

(Days 1-5)

Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if –

(a) the child dies or is seriously harmed in the local authority’s area, or

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

The local authority must report any event that meets the above criteria to the Child Safeguarding Practice Review Panel. They should do so within five working days of becoming aware that the incident has occurred.

The local authority should also report the event to Ofsted, Department for Education (DfE), the relevant child death review partners and the relevant safeguarding partners within five working days. Where a looked-after child has died (including cases where abuse or neglect is not known or suspected), the event

should also be reported to Ofsted, the safeguarding partners and the child death review partners

Consideration for notification

When a serious incident becomes known to the safeguarding partners, they must consider whether the case meets the criteria for a local review. When safeguarding partners are deciding when it is appropriate to commission a local review of a case or cases, they must take the following into account:

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

Safeguarding partners should also have regard to the following:

- where the safeguarding partners have cause for concern about the actions of a single agency.
- where there has been no agency involvement and this gives the safeguarding partners cause for concern.
- where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around.
- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.

Some cases may not meet the definition of a serious child safeguarding case but nevertheless raise issues of importance to the local area. That may include where there has been good practice, poor practice or a near miss situation. Safeguarding partners may choose to undertake a Local review in these circumstances as opposed to a Safeguarding Practice Review.

Notification pathways

All staff members upon becoming aware of an incident that may reach the criteria of a serious incident should in the first instance have a conversation with their line manager in accordance with their internal safeguarding processes.

Police and Health

Where the police or any health agency are the first to be aware of the death or serious harm of a child they should contact Children's Social Care Front Door and the Kirklees Safeguarding Children Partnership Business Unit. They will also (most likely) need to contact each other as per their normal safeguarding procedures. Notification of a serious incident to the KSCP Business Unit should be made using the Serious Incident Referral Form (Appendix 2)

Children's Social Care

Where Children's Social Care are the first to be aware of the death or serious harm of a child they should complete the Serious Incident Referral Form (Appendix 2) and send to their Front Door Service and Kirklees Safeguarding Children Partnership Business Unit. Once the Serious Incident form has been completed this is sent to the KSCP to forward to the Service Director for Quality Assurance

Kirklees Safeguarding Children Partnership

The Kirklees Safeguarding Children Partnership will confirm via Children Services and the Independent Chair for KSCP that the criteria for a serious incident has been met and the case needs to progress to the information gathering stage. The KSCP will at this stage notify Ofsted upon the direction of the Director of Children Services. The KSCP will also ensure that all 3 key partner agencies (CCG, Children's Social Care and Police) are aware and kept up-to-date with the serious incident, they will ensure that the relevant child death notification paperwork is obtained and progressed to CDOP as appropriate.

All other agencies

Any agency including the voluntary and community sector may submit an incident or a case for consideration for notification and / or a review. The safeguarding lead for that agency should contact the SPR Co-ordinator or Business Manager at the KSCP Business Unit in the first instance to discuss the case details.

Notification Stage
(Days 1-5)

Information Gathering

Working Together now compels safeguarding partners to undertake a *concise investigative exercise to understand both the relevant circumstances and the involvement of local agencies*. This should be completed and the findings sent to the Child Safeguarding Practice Review Panel within 5 working days of learning of the Serious Child Safeguarding Case. At the same time *they should also advise the Panel whether in principle they already consider that a local child safeguarding practice review is appropriate or not*.

As a result of this significant change to the review process and the tight timescales the initial information gathering and the decision about whether and what type of review is required must take place quickly. The information from agencies, a summary of the discussion at the panel, the decision will be recorded in the Rapid Review template and an outline of the terms of reference will be returned to the Child Safeguarding Review Panel within 15 working days of learning of the Serious Child Safeguarding Incident.

Information Gathering Stage (Days 5- 10)

The Safeguarding Children Partnership Business Unit will send out an Information Gathering Tool (Appendix 3) to all partner agencies and any others who are known to have involvement with the case. Partner agencies will be asked to inform the Safeguarding Children Partnership Business Unit if they are aware of any other e.g. 3rd sector agencies that are or have been also involved with the case so that they may also be able to complete an Information Gathering Tool

The Information Gathering Tool is intended to gather concise information regarding the agency's involvement, a brief chronology surrounding the events leading up to the incident and initial thoughts regarding the case's suitability for a Local or National Children's Safeguarding Practice Review, a Single Agency Review

or a single or multi-agency audit. It would be helpful at this stage for agencies to identify the practitioners involved in this case in order to make the planning of a Practice Learning Event more efficient should one be required.

This Information Gathering Tool must be completed and returned to the Safeguarding Partnership Business Unit within 5 days to allow the efficient functioning of a Local Child Safeguarding Practice Review Panel.

Preparation for the Local Child Safeguarding Practice Review Panel

In order that decisions can be made efficiently and effectively at the panel the following information / paperwork will be made available to panel members

- The completed serious incident notification form
- All returned Information gathering tools
- Agenda for Panel Decisions (Appendix 4)
- Serious Incident Rapid Review Template (Appendix 5)
- Terms of Reference Template (Appendix 6)
- A list of possible suitable review authors

Panel and Decision

The Local Child Safeguarding Practice Review Panel will comprise representatives from the Clinical Commissioning Group, Police and the Local Authority; this mirrors the new Safeguarding Children Partnership arrangements. It will be chaired by the Safeguarding Children Partnership Independent Chair. It may be a physical or a conference telephone call and will follow the set agenda (Appendix 4). Representatives from other agencies who have had significant involvement with the child or family will also be invited.

The purpose of the panel is threefold:

- Determine whether the criteria for a review is met and what type of review will be undertaken
- Write the draft Rapid Review and outline further information that is required
- Write the terms of reference for the review where the criteria is met

The 4 options for types of review are:

1. National Children's Safeguarding Practice Reviews
2. Local Children's Safeguarding Practice Reviews
3. Single Agency Review
4. Single or Multi-Agency Audit

The definitions of each type of review are in the Information Gathering Tool and will be available to everyone at the Panel meeting.

When safeguarding partners are deciding when it is appropriate to commission a local review of a case or cases, they must take the following into account

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

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

Safeguarding partners must also have regard to the following circumstances

- *where the safeguarding partners have cause for concern about the actions of a single agency*
- *where there has been no agency involvement and this gives the safeguarding partners cause for concern*
- *where more than one local authority is involved, including in cases where families have moved around*

Decision Stage (Day 10)

Decision

Once a decision has been made about whether and what type of review is needed the Chair of the Local Child Safeguarding Practice Review Panel should complete the Serious Incident Rapid Review Template (Appendix 5).

Other types of review

If another type of review, for example a Domestic Homicide Review, MAPPA Serious Case Review or Safeguarding Adults Review, is being carried out, safeguarding partners should 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.

The Local Child Safeguarding Practice Review Sub-Group will need to be assured that any other review is progressing in a timely way and that the Local Child Safeguarding Practice Review Sub-Group is aware of any actions so that they can be embedded with the same oversight and vigour as those actions arising from Safeguarding Practice Reviews.

Terms of Reference for the Review

Following the decision the terms of reference should be agreed.

Minimally these decisions should include:

- The time period that the review will cover
- The agencies who will need to complete a full chronology with analysis and attend Practice Learning Event(s) and the contact name within the agency if possible
- The timescale for the completion of the review (with reference to the flowchart and timescales in this guidance)
- Who will be the author and lead reviewer of the report
- If an outside expert is required
- What other parallel investigations / reviews may impact on this review
- Key Issues identified by the Panel that will need to be addressed

A template for the Terms of Reference can be found in Appendix 6 of this

**Rapid Review
(by Day 15)**

document

Rapid Review

Working Together now compels safeguarding partners to undertake a concise investigative exercise to understand both the relevant circumstances and the involvement of local agencies. This is known as a Rapid Review and must be sent to the (National) Child Safeguarding Practice Review Panel within 15 days of a serious incident.

The Serious Incident Rapid Review includes:

- A brief description of the serious incident
- Whether the criteria for a SCR or SPR has been met
- Brief outline of case history
- Action taken to safeguard the child or children
- Any themes of National concern that have been identified
- Immediate learning and how this will be disseminated
- Potential for additional learning
- Decision and rationale on the type of review that will be undertaken (if any)
- The agencies and staff who have made this decision

This document will be sent by the KSCP to the [National] Child Safeguarding Practice Review Panel along with the initial Terms of Reference within 15 days of the notification of a serious incident.

Guidance from the National Panel on Rapid reviews indicates that the best ones provide a robust platform from which to improve practice, thoughtful, reflective analysis of the case and incident from an organisational context and clearly set out next steps

Whether or not the Local Child Safeguarding Practice Review Panel has recommended it, the [National] Child Safeguarding Practice Review Panel may decide to undertake the case a National Children's Safeguarding Practice Review, however, the safeguarding partners should undertake necessary planning, for a National Review.

Chronologies

Agency chronologies are obtained using the Chronolator software. The Safeguarding Children Partnership Business Unit may send out guidance and the Chronolator template to agencies if it has been agreed need to complete one. The template must be followed and not altered as this allows the software to easily compile a clear, multi-agency chronology. The Key Lines of Enquiry and timeframe for review identified in the Terms of Reference will also be sent out with the Chronolator template to enable agencies to consider their analysis.

It is important that the chronology is completed fully and that consideration is given to the analysis section of the template.

Chronology authors may wish to consider the following when completing the analysis section:

- Systems - Look at the context within which people are working – what was going on at that point in time?
- Look openly, honestly and critically at individual and organisational practice
- Consider the nature of your agency/service involvement over time, both
 - individually and within an inter-agency context
 - Identify good practice
 - Identify learning/improvements for your organisation/service

The template must be completed and returned within 14 days. As these are returned to the Safeguarding Children Partnership Business Unit they will be combined into one, colour coded, multi-agency chronology and made available to the Independent Author so that they can begin to understand the case, draw out the Key Practice Episodes and begin planning for the Local Child Safeguarding Practice Learning Event.

Independent Author (Lead Reviewer)

The safeguarding partners are responsible for allocating or commissioning and supervising reviewers for local reviews. When allocating or commissioning a reviewer, safeguarding partners should consider whether those they commission have the following:

- *professional knowledge, understanding and practice relevant to the ability to undertake and write local child safeguarding practice reviews*
- *knowledge and understanding of research relevant to children's safeguarding issues*

Safeguarding partners should also:

- *seek to assure themselves that the reviewer they select is able to produce a quality review within the agreed timescale*
- *consider whether the reviewer has any conflicts of interest which could restrict his/her ability to identify improvements*
- *clearly commission the reviewer, taking into account the need for the review to be proportionate to the circumstances of the case and for it to establish and explain the reasons why the events occurred as they did*
- *ensure that any contract with a reviewer covers the above key points and that it provides for the safeguarding partners to remove the reviewer if this is necessary*

Review Writing Stage (Days 10-60)

If considering a commission of an Author expressions of interest will be sought from a pool of reviewers (provided by the [National] Child Safeguarding Practice Review Panel or by the Safeguarding Children Partnership Business Unit). The process for buying in a reviewer needs to be robust to ensure that the review produced takes into account the requirements outlined by Working Together 2018, reproduced above. It is imperative that the reviewer understands the process operated in Kirklees and the timescales we are adhering to.

Templates for the Expressions of interest and reviewers commissioning letter are found in the Appendices 7, 7a, 8 and 9.

Once appointed the reviewer will receive copies of the notification, information gathering tools, Rapid Review and begin to formulate a view on what the key practice episodes should be.

Local Child Safeguarding Practice Learning Events

Reviews are to be conducted using systems methodology, there are a number of ways of enacting a systems methodology but the key features relate to the review being able to *provide a way of looking at and analysing front line practice as well as organisational structures and learning. The methodology should be able to reach recommendations that will improve outcomes for children.*

Review processes within Kirklees continue to be evaluated and evolve to ensure best practice to support processes and identify learning. The AI methodology introduced in the KSCP 2018 has been used on two case file audits identifying and understanding good practice, the findings of which have been fed back to the Partnership. Consistent feedback from practitioners and managers show that this work is valued and important in learning lessons. Key changes to the approach of undertaking SPRs and LPRs across the year have included:

- Moving away from chronologies to identification of key practice episodes through scrutiny of timelines
- Practitioner involvement, at key strategic points within the reviewing process
- Moving away from “recommendations” to the identification of “learning points” within reviews
- SMART actions on plans being developed restoratively with partner agencies to respond appropriately to learning points

Further Working Together 2018 states:

The purpose of a Practice Learning Event is to facilitate the sharing of experiences between practitioners, to clarify how individuals understood the situation at the time and the roles of each agency

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

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

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

Practice Learning Event (Practitioners)

A well run Local Child Safeguarding Practice Learning Event enables the reviewer to understand the context of any decision made or actions taken or not taken. It ensures that an understanding of the context of the review is clear and that agencies are able to question, discuss and highlight differences of opinion regarding the case. This needs to be carefully managed by a skilled facilitator to ensure that any practitioners involved are able to contribute fully and do not feel blamed. A leaflet outlining the purpose of the Practice Learning Event and the expectations of those practitioners attending will be sent out (Appendix 14)

The Local Child Safeguarding Practice Learning Event should take place 14 days after the information gathering or chronology return deadline and should focus on the key themes identified in the Terms of Reference and the Key Practice Episodes identified by the Reviewer. Practitioners and Managers will be invited to correct any inaccurate information or interpretations and to provide further information on the context of the case.

The Local Child Safeguarding Practice Learning Event should also act as an opportunity for on the spot problem solving. Where improvements to the current local safeguarding system, are identified, be they for a single agency, multiple agencies or the system as a whole, these should be captured and form the basis of the authors findings and final plan.

Managers will be expected to comment on the feasibility of the proposed recommendations and also update on any current work that is being undertaken which may be relevant to the review. Managers will also have the opportunity to identify opportunities for improvements to the current local safeguarding system

Family involvement

Family members will be given the opportunity to contribute to the Local Child Safeguarding Practice Review process by considering the services and support provided by various agencies and whether this was appropriate to their needs. Family members are not just parents / carers but will include extended family as appropriate. Family members may also be asked to comment on issues associated with the publication of the final review. Which family members are contacted and at what point in the review will be determined on a case-by-case basis. It may not be possible to speak to some members due to concurrent criminal investigations or trials.

It is recognised that contacts with family members should be handled sensitively and, where possible, via a professional already known to the family. The Kirklees Safeguarding Children Partnership Business Unit manager will lead on the approach and discussions with the family. They may visit with the author or a professional already known to the family. A template for the letter and leaflet to be sent to families is found at Appendix 17 and 18.

Draft Report

The reviewer has 22 days from the Local Child Safeguarding Practice Learning Event (or the last learning event if there was a need for a separate one for the managers) to write the 1st draft of the report a template for this can be found in Appendix 19. The report should avoid unnecessary detail regarding the child, family and incident *be written in such a way that what is published avoids harming the welfare of any children or vulnerable adults involved in the case.* This approach ensures that the report can be published, in full, upon completion, barring exceptional circumstances related to parallel, legal processes such as criminal investigations or trials.

Safeguarding partners must ensure that the final report is of satisfactory quality and includes:

- *A summary of recommended improvements for the safeguarding partners or others to safeguard and promote the welfare of children*

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

The author is not expected to formulate recommendations or an action plan but simply to state the learning or findings from their analysis of the information provided in the course of writing the review.

It is common for disagreements to arise between involved agencies and the reviewer regarding the findings / recommendations of the review. Agencies will be reminded to make their objections based on anything that may be factually inaccurate or unfairly representative of their current position, i.e. not sufficiently capturing how any agency may have moved on since the review, however, a Local Child Safeguarding Practice Review can often make uncomfortable reading and agencies should not attempt to compromise the independence of the reviewer. It is desirable to wherever possible reach agreement about an appropriate way forward and agencies will be given the opportunity to raise their concerns either at the LCSPR Sub-Group or the Executive Partnership meeting where the review will be discussed and signed off. Should disagreements remain these will be captured by the author in the review, clearly stating what the disagreement was, why consensus could not be reached and how the agency intends to proceed.

**Draft Report
(Day 39-60)**

Concurrent Criminal / Coroners investigations

The police representative for the LCSPR is responsible for monitoring any concurrent criminal investigations in the review cases and reporting updates back to the LCSPR work stream. As contact with family members and final publication of the SPR is often contingent on the conclusion of these parallel processes it is vital that these updates are given in a timely way. The CDOP coordinator for the KSCP will make the KSCP Review Coordinator aware of any updates to Coroners investigations.

Independent Chair, Chair of LCSPR Sub-Group and KSCP Review Co-ordinator approval

The first draft of the review will be read by the Independent Chair, Chair of LCSPR Sub-Group and KSCP Review Co-ordinator who will ensure that the terms of reference have been met, the quality of the review is high and work to identify any areas of sensitivity for partners agencies which may need to be addressed outside of the LCSPR Sub-Group or Kirklees Safeguarding Executive settings. Areas of possible disagreement will be discussed with the reviewer to ensure these are captured as outlined in the previous section.

LCSPR Sub-Group approval

Once the draft review is complete it will be sent to the LCSPR Sub-Group to be considered, amended and approved. It will be sent at least 3 weeks before the Sub-Group meeting. The Sub-Group will only have one opportunity to do this so it is imperative that all members read and make all their amendments or comments known at the Sub-Group meeting that considers the review. If members give their apologies for the meeting they can give their comments electronically, if comments are not received by the time of the meeting it will be assumed that the member has no comments or amendments to make. The chair of the Learning and Development Sub-Group or the Learning and Development Officer for the Safeguarding Children Partnership must attend this meeting in order ensure the appropriateness and achievability of any actions related to learning as per the LCSPR Sub-Group Terms of Reference (Appendix 21)

Approval and Publication stage (days 61 to 90)

If there is not a Sub-Group scheduled within 14 days of the completion of the draft then an extraordinary one can be scheduled to consider and approve the review. Meetings can be real or virtual. Members of the LCSPR should read the draft prior to the meeting and have their comments and amendments ready. In

the meeting the review will be discussed, page by page and any agencies comments noted in the minutes and amendments to be agreed by the Sub-Group before being submitted back to the author. It may be desirable for the author to attend this meeting in person to hear any of the comments or requests for amendment directly from agencies.

In order to ensure that this meeting is effective members should be mindful of requesting changes related to style and preference and focus on any inaccuracies in the review and the relevance and achievability of the recommendations and action plan.

The minutes of the meeting must be completed within 48 hours and sent with suggested amendments back to the reviewer for updating. If the reviewer disagrees with any of the amendments they should contact the KSCP Review Co-ordinator to resolve this. The reviewer will then amend the review within 48 hours and return to the Safeguarding Children Partnership Unit.

Kirklees Safeguarding Executive Approval

The review should then be sent to members for the Kirklees Safeguarding Executive for approval, again this will be sent at least 3 weeks before the Safeguarding Executive Group meeting. As with the LCSPR the Safeguarding Executive Group will only have one opportunity to make their comments and amendments so it is imperative that all members read and make all their amendments or comments known. If comments are not received it will be assumed that the member has no comments or amendments to make.

Any amendments suggested by the Safeguarding Executive Group will be sent back to the reviewer for updating. If the reviewer disagrees with any of the amendments they should contact the KSCP Review Co-ordinator to resolve this.

The reviewer will then amend the review within 48 hours; this is now the final version of the Review and will be sent to the Safeguarding Partnership Business Unit.

Action Plans

After the sign off by the Kirklees Safeguarding Executive Group the review is now final and the action plan can be developed from the authors findings. This will be done through the LCSPR Sub-Group and using the KSCP's Enable Audit tool.

The KSCP Business Unit will create an Enable Audit using the Authors findings as the headings. Agencies will be expected to respond to the findings outlining what actions they intend to undertake in response with appropriate timescales. Where an agency does not feel a finding is applicable to them they will indicate this on the audit tool.

Agencies are responsible for updating their own section of this audit tool with progress on the actions they have set themselves and by attaching evidence that the action has been completed.

Enable can produce an easy RAG graphic indicating agencies progress and this will be reviewed at subsequent LCSPR Sub-Groups.

Formulating the action plan (following Safeguarding Executive Group approval)

Actions must be written in a SMART way and must be achievable in no more than 12 weeks (from date of publication or sooner if agencies wish to begin progressing the actions). Any recommendations or actions that are unlikely to be achieved in 12 weeks should be escalated to the Safeguarding Children Partnership under separate cover for consideration of a larger piece of work.

It is the responsibility of the LCSPR Sub-Group to ensure the actions are being progressed appropriately and to notify the Chair of the Safeguarding Children Partnership where it is likely that an action will not be achieved in the timescale or at all.

Firmly fixing lessons into practice

The LCSPR Sub-Group will work with the Learning and Development Sub-Group to ensure that the lessons from the Sub-Group are well understood by the local workforce and will undertake work to ensure that the lessons are fixed firmly into practice.

Actions that could be taken to firmly fix the lessons may include:

- Revision of existing single or multi-agency training
- Creation of a learning summary and arrange accompanying events to disseminate the learning from the review
- Adding any completed / amended policies / protocols to the practitioners toolkit and promoting their use
- Commissioning / developing specialist training or e-learning
- Focused evaluation of practitioner knowledge on a particular area of practice

The Learning and Development Sub-Group will take responsibility for the provision of training events and resources to support the dissemination of the lessons and changes to practice and the LCSPR will focus on assurance that the lessons have been embedded across the partnership and that these changes to practice are having an impact on outcomes for children and families.

Notification to involved Practitioners, Family members, Safeguarding Partnership, [National] Children's Safeguarding Practice Review Panel and Sec. of State

Safeguarding partners must send a copy of the full report to the Child Safeguarding Practice Review Panel and to the Secretary of State at least seven working days (a) after completion or (b) before publication, whichever is the sooner. They should 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. Safeguarding partners must have regard to any comments the Panel or the Secretary of State make with regard to publication.

The Safeguarding Partnership Business Unit will send out a copy of the Final review to the Safeguarding Children Partnership, [National] Children's Safeguarding Practice Review Panel and Sec. of State informing them of the intention to publish in 7 days' time (Appendix 23). A notification (but not the review) will be sent to involved practitioners and family members at the same time informing of the intention to publish in 7 days' time. Should they wish to read this prior to publication this can be arranged with the KSCP,

If there is a reason why the review cannot be published or if there is a reason why publication is to be delayed (i.e. due to exceptional circumstances related to parallel, legal processes such as criminal investigations or trials then a notification should be sent to the Safeguarding Partnership, [National] Children's Safeguarding Practice Review Panel and Sec. of State stating the reasons why the review cannot be published or the reasons for the delay to publication with an expected date at which the review can be published.

It is expected that non-publication is an unlikely scenario due to the way that the review will be written, focusing on the learning and improvements to be made rather than the individual circumstances of the child and their family and the incident that led to the review.

Safeguarding partners must publish the report, unless they consider it inappropriate to do so. In such a circumstance, they must publish any information about the improvements that should be made following the review that they consider it appropriate to publish. Given that this is about promoting and sharing information about improvements, both within the area and potentially beyond, there is a presumption that the full report should be published. 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.

Publication (Day 90)

Media Strategy

The review may have or may upon publication attract media attention. An assumption should be made that every review will attract some level of media attention the Kirklees Safeguarding Children Partnership Business Manager and the Independent chair should meet with their designated media officer in order to discuss the management of any media interest. A statement from the Safeguarding Children Partnership should be prepared that will be the only statement that any agency uses about the review. Further guidance on a Media Strategy for reviews is found at Appendix 22

Publication

On the date notified to the involved Practitioners, Safeguarding Partnership, [National] Children's Safeguarding Practice Review Panel and Sec. of State the full review will be published on the Safeguarding Children Partnership website and will remain there for a period of 6 months. The review will be accompanied on the website with a copy of the action plan, the learning summary (Appendix 24) for the case and a statement from the KSCP. All Local Safeguarding Children Partnership Sub-Groups will also be notified that the review is now published and that they are free to share this with their agencies.

Appendices

1. Review Process Flowchart
2. Serious Incident Notification Referral Template
3. Information Gathering Tool for a Serious Incident
- 3a. Information Gathering Tool for the Learning Service for a Serious Incident
4. Agenda for panel decision
5. Serious Incident Rapid Review Template
- 5a. Template Letter—Submitting Rapid Review to the National Panel
6. Local Child safeguarding Practice Review Terms of Reference
7. Expressions of interest for author (and 7a for partner agencies)
8. Local Child Practice Safeguarding Review Authors Agreement (internal)
9. External author commissioning letter
10. Letter/ Email requesting completion of Chronolator
11. Chronolator template
12. Request for involved staff to attend Local Child Safeguarding Practice Learning Event
13. Agenda for Local Child Safeguarding Practice Learning Event
14. Information leaflet for involved staff
15. Key practice episodes guidance
16. Key practice episodes template
17. Letter for families
18. Information leaflet for families
19. Template for review
20. Template for action plan
21. Terms of reference for Safeguarding Practice Review Sub-Group
22. Media strategy guidance