Norfolk Safeguarding Children Partnership

Norfolk Child Safeguarding Practice Review Processes

REVISED MARCH 2025

Date ratified by Three Statutory Partners:	27 February 2025
Date for Guidance Review:	31 March 2026

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1. Background and Context

The responsibility for local safeguarding arrangements in Norfolk sits with the Local Authority, the Police and Health (led by Norfolk & Waveney Integrated Care Board, ICB lead for children and host of Norfolk's NHS Designated Child Safeguarding Team). This arrangement is made statutory under s16E of the Children and Social Work Act 2017, and Working Together 2023 and is supported by Norfolk's plan for Multi-Agency Safeguarding Arrangement (MASA).

The statutory partners are responsible for ensuring that when cases meet the criteria for child safeguarding practice reviews they have robust processes that meet the standards expected by the National Child Safeguarding Review Panel (hereafter referred to as the National Panel).

This document sets out the local processes for conducting Rapid Reviews , including actions for cases that do not meet the criteria. The processes are informed by the National Panel's Practice Guidance, published September 2022 and draws from examples of best practice nationally. It also references the National Panel's 2023 – 24 annual report.

The process guidance has been ratified by the three statutory agencies named in Working Together 2023, as below.

The named statutory partners take decisions on behalf of their organisation / agency and have power to commit resourcing, change policy, and hold their organisation to account in order to effect and implement local changes. They make the final decisions on commissioning local Child Safeguarding Practice Reviews. The NSCP independent scrutiny team provides scrutiny of their decisions and appropriate challenge and advice where required.

Governance for these arrangements sit with the NSCP's Safeguarding Practice Review Group (SPRG), which is made up of senior representatives from Children's Services, Police and Health, with additional members from Education and Cafcass. The group also has legal advice provided by Norfolk County Council's internal team, nplaw. The SPRG has an independent chair who provides challenge and guidance to the partners. The chair is responsible for guiding the functions of the panel and ensuring that decision making is exercised equally by the partners' delegated representatives, taking the lead on any issues that arise between the partners. The chair is also responsible for ensuring that learning and key messages are reported to the NSCP and the partners are alert to thematic issues as well as examples of best practice.

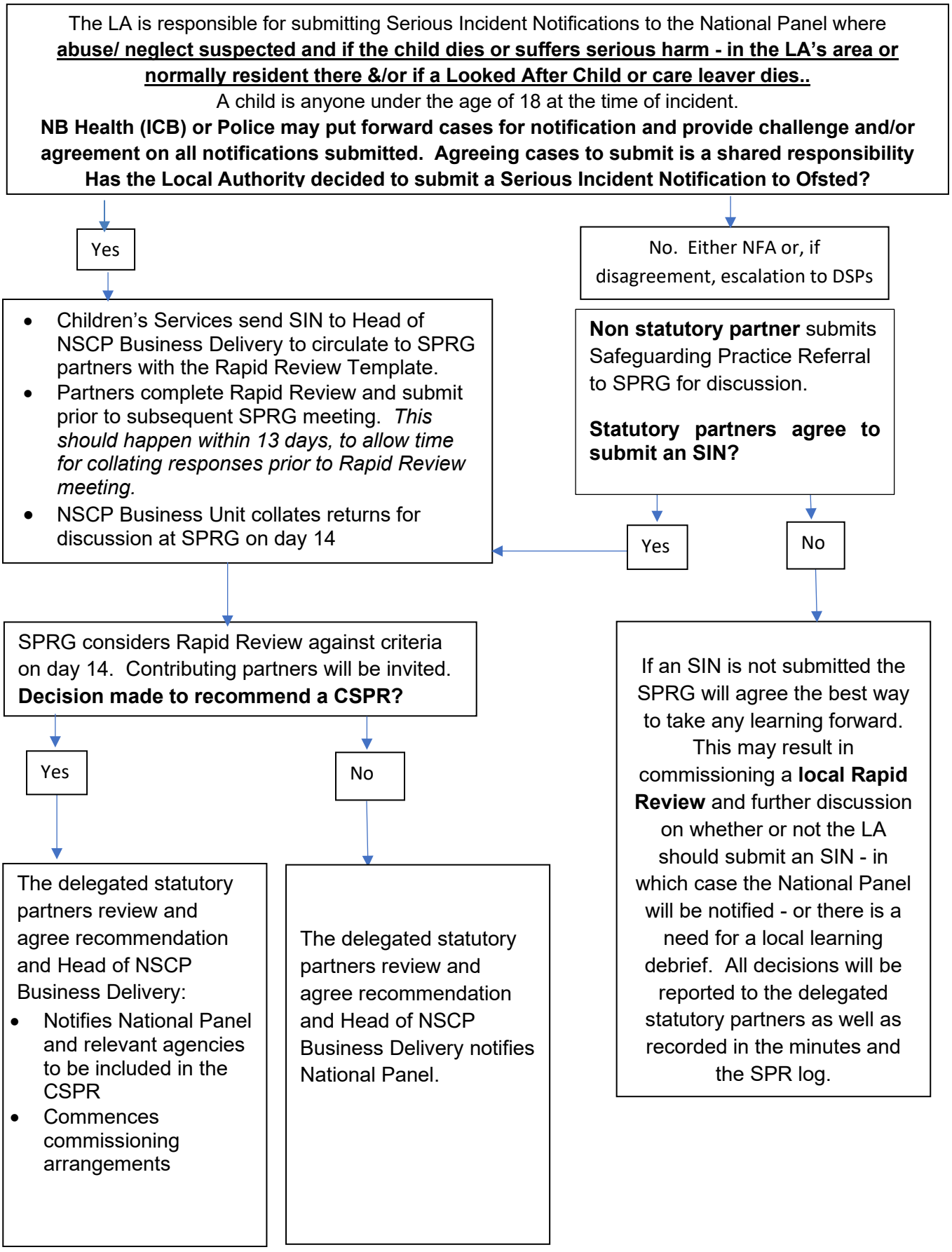
The SPRG is supported by the NSCP's Business Unit. In addition to providing administrative support, the Head of NSCP Business Delivery is responsible for co-ordinating the review process, communicating with the National Panel and partners on any cases referred to SPRG and leading on the dissemination of learning from child safeguarding practice reviews in the multi-agency arena.

The guidance will be reviewed annually or on publication from any further direction from the National Panel or relevant regulation or guidance in statute by the Secretary of State as stated in s22 of the Children and Social Work Act 2017.

February 2025
Abigail McGarry
Head of NSCP Business Delivery

	Delegated Safeguarding Partner	Lead Safeguarding Partner
Norfolk County Council	 Sara Tough, OBE Executive Director Children's Services	 Tom McCabe Chief Executive Officer
NORFOLK CONSTABULARY Our Priority is You	 Chris Balmer T/Assistant Chief Constable	 Paul Sanford Chief Constable
NHS	 Patricia D'Orsi Executive Director of Nursing Norfolk and Waveney Integrated Care Board	 Tracey Bleakley Chief Executive Officer, Norfolk & Waveney Integrated Care Board

2 Flowchart for Referrals to SPRG



3. Record of Serious Incident Notification

The decision to submit a Serious Incident Notification (SIN) to the National Panel sits with the Local Authority. It is the responsibility of the Local Authority to submit when:

- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed

The local authority should notify the panel of any incident that meets the above criteria via the Child Safeguarding Online Notification System. It should do so within five working days of becoming aware the incident has occurred. Though the responsibility to notify rests on the local authority, it is for all three safeguarding partners to agree which incidents should be notified in their local area. Often these decisions will be made during the strategy discussion following the death or incident. Where there is disagreement, the safeguarding partners will contact the Head of NSCP Business Delivery to convene a meeting with the SPRG Chair and/or put on the SPRG agenda. In exceptional circumstances, the cases may be escalated for discussion with the Delegated Safeguarding Partners, who make the final decision. The NSCP's Independent Scrutiny Team will provide appropriate challenge and advice.

All statutory partners are expected to record serious incidents for their internal agency processes. SPRG has a standing item on cases causing concern where these can be discussed and any challenge or disagreement minuted.

The local authority must notify the Secretary of State for Education, and Ofsted of the death of a looked after child. The local authority should also notify the Secretary of State for Education and Ofsted of the death of a care leaver up to and including the age of 24. This should be notified via the Child Safeguarding Online Notification System. The death of a care leaver does not necessarily require a rapid review or local child safeguarding practice review. However, safeguarding partners at SPRG will consider whether the criteria for a serious incident has been met and respond accordingly, in the event the deceased looked after child was under the age of 18 or a care leaver. If local partners think that learning can be gained from the death of a looked after child or care leaver in circumstances where those criteria do not apply, they may wish to undertake a local child safeguarding practice review.

The local authority, on behalf of the safeguarding partners, has a duty to notify the panel about all serious incidents that meet the criteria. Making a notification, will ensure that learning is identified and fed back into the system to prevent future harm or death. The link to the Child Safeguarding Online Notification form for local authorities to notify incidents to the panel is available on the Report a serious child safeguarding incident page on GOV.UK.

The Department for Education (DfE) is responsible for publishing annual serious incident data. This data is extracted from the notifications submitted by local authorities, so accuracy when completing the online notification form is key. All incidents meeting the criteria should be notified as "serious harm" or "death", except where there is a clear reason to notify as "other", for example, in cases where the notification relates to a perpetrator. A notification regarding the suicide of a child should be made where abuse or neglect is a factor.

Other non statutory partners who have functions relating to children – e.g. education or early years - should inform the safeguarding partners of any incident they think should be considered for a child safeguarding practice review. This may be through a local referral or be requested

as taken under the cases causing concern agenda item at SPRG. These cases should be referred to the Head of NSCP Business Delivery through the respective safeguarding teams and with the guidance from SPRG members. SPRG should not be used as an escalation process.

Serious Harm

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, i.e. meets the criteria set out under Section 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017), which states:

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 LA also must notify secretary of state and Ofsted if a LAC child dies (reg 40 Children's Homes (England) Regs 2015.

This definition must be interpreted in a way which allows for the most serious incidents of abuse and neglect in all categories of harm to be identified and referred for consideration (this will include sexual abuse (which includes child sexual exploitation), neglect, physical and emotional abuse). Interpretation of the criteria must not exclude children or young people because of their age and the definition does not apply solely to children who have suffered severe physical injuries who have self-evidently suffered severe physical harm that is likely to affect their global development. [1]

The National Panel's guidance recognises the challenges of the term 'serious harm' and have included this in their guidance:

> *Often the judgement on whether the level of harm to a child is serious is quite straight forward. This may be because the child has a life-changing injury, long-term impairment resulting from an injury, or an injury that is clearly life-threatening - for example, requiring resuscitation or intensive care treatment. However, some incidents are not so clear. In these circumstances it is important that safeguarding partners use their professional judgement to determine whether the harm is serious.*
>
> *In cases of physical injury which are neither life-threatening, nor life-changing, consideration should be given to the extent, persistence and severity of the injuries sustained and any context of wider neglect or abuse. Isolated bruises or limb fractures in infants or children would not normally be considered serious unless accompanied by internal injuries (for example abusive head trauma, abdominal injuries) or they are of a degree or extent likely to be life-threatening or life changing.*

[1] Alleged child perpetrators may also be the subject of a review if the definition of 'serious child safeguarding case' is met.

In cases of sexual abuse, neglect or emotional abuse consideration should be given to the extent, persistence/repetition, and severity of the abuse/neglect, how this may have impacted on the child's development and well-being, and any likely long-term psychological harm, bearing in mind the child's development and any other contextual factors. A single incident of sexual abuse may result in serious emotional harm, therefore, although persistence/repetition is a factor to be considered in these cases it should not be relied on as the sole determinant of seriousness or an indicator of longterm impact.

Children's Homes A referral must be made when a child has died or is seriously injured in a children's home (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.

The Children's Homes Regulations 2015, including quality standards guide provides examples of incidents that are likely to be considered serious. These include:

- a child being the victim or perpetrator of a serious assault
- a serious illness or accident; NB serious illness or accident would include matters such as broken bones, when a child loses consciousness or situations that require admittance to hospital for more than 24 hours. Notification should consider and include cases:
- a serious incident of self-harm
- serious concerns over a child's missing behaviour
- about the death of a child
- about the referral of someone working in the home to your Local Safeguarding Children Board [now Partnership]
- if you know or suspect that a child has been involved in or subject to sexual exploitation (you should be able to provide evidence)
- about a serious incident with a child that required police involvement
- about an abuse allegation against the home or someone working there
- if a child protection enquiry has begun or finished

If an SIN is submitted, Children's Services will immediately notify the NSCP Business Unit in order that a Rapid Review is triggered.

Notifying the National Panel of a Rapid Review

The NSCP Business Unit will liaise with the National Panel for Child Safeguarding Practice Reviews and confirm the date for completion, i.e. 15 working days from the point of Serious Incident Notficiation. In addition, if any review requires a migration, border, or citizenship related contribution from the Home Office, the Chief Caseworker Unit from the Home Office will also be notified at CCUsafeguarding@homeoffice.gov.uk.

4. NORFOLK SAFEGUARDING CHILDREN PARTNERSHIP
Safeguarding Practice Review Referral Form
for Non-Statutory Partners

Referral to the Norfolk Children's Safeguarding Partnership as a possible Serious Child Safeguarding Incident

Guidance note – It is the responsibility of the Local Authority to submit a Serious Incident Notification (SIN) to Ofsted when:

- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed

The decision to submit is shared with police and health (the ICB), who are equally responsible for identifying cases that meet the criteria above.

Non statutory partners – e.g. education, early years, health providers, etc. - may have legitimate concerns about a safeguarding incident and consider that there is learning for the multi-agency safeguarding partnership. If the senior manager or professional in a specialist safeguarding role believes that the circumstances of the child constitute a serious child safeguarding case she/he must refer the circumstances to the NSCP Business Unit using the Safeguarding Practice Review Referral Form.

The National Panel provides clear guidance on the responsibility to notify:

Where an agency other than the local authority becomes aware of an incident that appears to meet the criteria for notification, they should discuss this with their local authority counterparts to reach an agreement on whether or not to notify.

There may be instances where safeguarding partners do not initially agree on whether there is a need to notify the Panel following a serious incident. For instance, it may be unclear whether an incident appears to have met the criteria for notification, although we hope this guidance provides further help. Discussion between safeguarding partners about cases and the decision to notify is crucial. Strong partnership working is predicated on collaboration and open dialogue. Where agreement cannot be reached through dialogue between the safeguarding partners alone, we encourage using the support of appointed independent scrutineers to help resolve differences.

In order to support open dialogue and gather information about cases causing concern, where the Local Authority has not submitted a Serious Incident Notification, we have devised a referral form for partners to complete and submit to SPRG for discussion and consideration on whether Children's Services need to submit an SIN to Ofsted on behalf of the partnership and/or to proceed to a local Rapid Review, which will be undertaken in 15 working days. NB It is good practice for agencies working with the child or family to jointly complete the referral to SPRG.

Safeguarding Practice Review Referral Form

Background Information

Name of Child:

Date of Referral:

Agency Referral

Name of senior officer / named or designated officer	AGENCY & DESIGNATION/TITLE	CONTACT DETAILS – Address, telephone number & e-mail

Child and family composition

Child's Details

Name of Child		Date of Birth	
Ethnicity		Date of Death (if applicable)	
Brief details of any confirmed disability		Gender	
Currently looked after child?		Formerly looked after child?	
If yes give details			
Currently CP plan?		Former CP plan?	
If yes, give details			
Currently child in need ?		Formerly CIN?	
If yes, give details			
Name(s) of Siblings		Sibling's(s')' dates of birth	
Should the entire sibling group be considered in the scope of this review? Please provide detail here			
Home address			
Housing provider (if applicable/known)			
School or Early Years Provider			
Date of serious Incident or incidents being reported			

Location of serious incident if not the child's usual home address	
Is the incident the subject of a criminal investigation and, if so, who is the Senior Investigating Officer?	

Details of Parents/Carers, Significant Family Members and other significant adult or children linked to the case. Please include a genogram if possible.

Name and Address	Date of Birth	Relationship to Child	Any significant information known at this point

Other agencies known to be involved

Agency	Name of key individuals	Phone and email if known

Category of Abuse. The Categories listed below are used to support the National Panel collate data. Please select any that are relevant.

Abuse					
Domestic Abuse		Physical		HSB: extra-familial	
Alcohol		Physical: Self-Harm		HSB: intra-familial	
Drugs/Solvents		Physical: FGM		Faith-Based	
Neglect: Long standing		Sexual: inter-familial		Online	
Neglect: Recent		Peer on Peer		Bullying	
Exploitation					
Countylines		Trafficking		Sexual Exploitation	
Modern Slavery		Extremism		Forced Marriage	
Criminal acts/Potentially Criminal					
Gang violence		Filicide (parent kills child)		Road traffic accident	
Knife crime		Child perpetrator		Other (see below)	
Health/Medical Issues					
Injury		Self-harm		Shaken baby syndrome	
Life-limiting illness (natural causes)		Suicide		Sudden infant death syndrome	
Serious illness		Fabricated illness		Other (see below)	

Other: if you have responded other to any areas above/if the issue is not categorised, provide details

Case Background

This information will be used to determine whether to trigger a multi-agency Rapid Review. ***This is a significant step that commits substantial professional time and has capacity and resource implications and should have senior management sign off at submission****. Please ensure that the information you provide is accurate and does not omit significant details. If you are uncertain of details, please highlight this.*

Provide brief details of the child and the family background, including previous serious incidents and services provided

Provide brief details of the incident that triggered this referral and why it constitutes a consideration by the Safeguarding Practice Review Group.

Use the chronology table below to highlight key events known to your agency leading up to and immediately following the incident. Rows may be added.

Date	Event

What action if any has been taken to safeguard the child or other children and adults affected? Do you have concerns about the current safety of this child or other family members?

Have you taken any steps to escalate these concerns outside of the Safeguarding Practice Review Group? Have any other investigations into the incident been triggered? If so, please provide details and outcomes.

Advice and Submission of this Form

To submit the form, or seek advice on its completion, contact:

Abigail McGarry
Norfolk Safeguarding Children Partnership Business Manager
abigail.mcgarry@norfolk.gov.uk
Tel: 01603 223335

You may also wish to refer to the
National Child Safeguarding Review Panel's Practice Guidance

For completion by NSCP Business Unit only

Details of decision as to whether to convene a Rapid Review, including:

- date of the SPRG meeting
- details of the discussion, including any disagreement noted
- decision reached and reasons for decision.
- actions agreed

Once completed the form should be returned to the referrer and shared with the NSCP.

Date of SPRG meeting		Name & Role of officer recording decision	
Points to note: • debates • outcomes • decision & actions			

5. NORFOLK SAFEGUARDING CHILDREN PARTNERSHIP

Norfolk Safeguarding Children Partnership

Rapid Review Template

Purpose of the Rapid Review

In line with *Working Together 2023*, the aim of this Rapid Review is to enable safeguarding partners to:

- gather the facts about the case, as far as can be readily established;
- 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 & promote the welfare of children;
- decide what steps to take next, including whether or not to undertake a child safeguarding practice review.

Decision about whether to conduct a Local Child Safeguarding Practice Review

Guidance: Norfolk Safeguarding Children Partnership (NSCP) is holding a Rapid Review of the circumstances surrounding a serious child safeguarding incident. The responsible officer is required to return a response in 15 days. The NSCP recognises the resource and capacity issues this involves, and this template is issued on the grounds that either (a) the case has met the criteria for the Local Authority to submit a Serious Incident Notification to Ofsted; or (b):a partner has submitted compelling evidence that the case meets the criteria for undertaking a local Rapid Review to establish the extent of harm and/or learning to be gained.

In this instance, Norfolk County Council has submitted a Serious Incident Notification.

*The partnership is required to decide whether it will conduct a local safeguarding practice review or what other action to take and report its decision to the National Child Safeguarding Practice Review Panel by ****. The Rapid Review will be considered by the NSCP's Safeguarding Practice Review Group (SPRG) on ****. The SPRG requires information from member agencies to inform decision-making. This document provides a summary of the information received to date, including details of the child, family and the incident.*

*The Rapid Review template must be submitted to the Head of NSCP Business Delivery, abigail.mcgarry@norfolk.gov.uk by **** on ****. NB All boxes will expand. Delay in providing relevant information may seriously impair the ability of the partnership to reach the best decision. The NSCP Business Unit will collate all single agency Rapid Reviews into one coherent document for decision-making at SPRG*

Details of the individual and agency completing this form

Name **Agency & Designation/Title**	**CONTACT DETAILS** **including direct line, telephone number & email**	**Date** **Completed**

Background Information *(This should be completed before this form is sent out)*

For completion by NSCP Business Unit: **Reasons for completing the Rapid Review**
For completion by NSCP Business Unit: **Time period to be covered by agency submission *(NB additional earlier background information should be submitted if it will inform the decision making)***

Family details **For completion by NSCP Business Unit:**

NB All agencies are asked to check whether the details below match information held on their systems. Please note any significant anomalies.

Name of Subject Child		Ethnicity	
Also Known as		NHS Number	
Date of Birth		Date of Death (if applicable)	
Brief details of any confirmed disability		Gender	
Currently looked after child?		Formerly looked after child?	
If yes give details			
Currently CP plan?		Former CP plan?	
If yes, give details			
Currently child in need?		Formerly CIN?	
If yes, give details			
Name(s) of Siblings		Sibling's(s')' dates of birth	
Should the entire sibling group be considered in the scope of this review? Please provide detail here			
Home address			
Housing provider (if applicable/known)			
School or Early Years Provider			
Location of serious incident if not the child's usual home address			
Is the incident the subject of a criminal investigation and, if so, who is the Senior Investigating Officer?			

Category of Abuse

The Categories listed below are used to support the National Panel collate data. Please select any that are relevant based on the information held by your agency.

Abuse					
Domestic Abuse		Physical		HSB: extra-familial	
Alcohol		Physical: Self-Harm		HSB: intra-familial	
Drugs/Solvents		Physical: FGM		Faith-Based	
Neglect: Long standing		Sexual: inter-familial		Online	
Neglect: Recent		Peer on Peer		Bullying	
Exploitation					
Countylines		Trafficking		Sexual Exploitation	
Modern Slavery		Extremism		Forced Marriage	
Criminal Acts/Potentially Criminal					
Gang violence		Filicide (parent kills child)		Road traffic accident	
Knife crime		Child perpetrator		Other (see below)	
Health/Medical Issues					
Injury		Self-harm		Shaken baby syndrome	
Life-limiting illness (natural causes)		Suicide		Sudden infant death syndrome	
Serious illness		Fabricated illness		Other (see below)	
Other: if you have responded other to any areas above/if the issue is not categorised, provide details					

Details of Family Members and other significant adult or child (including carers at the time of the incident if known Please include a genogram if possible.

For completion by NSCP Business Unit: ***NB if the Rapid Review Author has any additional information please add it here***			
Name and Address	**Date of Birth**	**Relationship to Child**	**Any significant information known at this point**

Agency Information and Involvement

SUMMARY: Provide a *brief* summary of your agency's involvement with children and adults listed above. The National Panel requires a concise summary of the facts, so far as they can be ascertained, about the serious incident and relevant context; this should give sufficient detail to underpin the analysis against the Working Together criteria, but does not require lengthy detailed chronologies of agency involvement that can obscure the pertinent facts; *Give details of key events in chronological order including periods when your agency was involved and gaps in contact. NB if the involvement was extended over a period of time, use the date column to state start and end date.*	
Date(s)	**Details of involvement/Event/Key Practice Episode**

Analysis

<u>ANALYSIS:</u> Does your agency's involvement in this case highlight any of the following areas? These are relevant to the decision to conduct a local safeguarding practice review. **Please provide further details below, or record N/A (not applicable).** *Where appropriate, cross reference Analysis to the key practice episodes noted in summary above.*	
Child's Lived Experience & Voice *What was the child's true lived experience and how can their voice be heard in the review?*	
Cultural Awareness & Competence *How was the race, culture, faith, and ethnicity of the child and/or family considered by practitioners and did cultural consideration impact on practice?*	
Impact of disability and/or physical or mental health issues *Intersectionality is the interconnected relationship of social categorisations such as race, gender, and sexual orientation together with individual vulnerability and adversities suffered by the individual. Were any recognised risk factors present or absent and did they play a significant part in the child's lived experience?*	
Multi-Agency Working	
Gaps in provision	
Cross boundary working	
Institutional settings	
Need for Improvement *Can you identify clear agency and/or partnership actions to take forward*?	
Good practice identified *Does the review identify relevant good practice, and should this be disseminated across the system?*	

IMMEDIATE LEARNING/VIEWS ON LEARNING TO BE GAINED: Please use space below to summarise your agency's response to this case in terms of: • *immediate safeguarding arrangements of any children involved;* • *any immediate learning already* • *plans for the dissemination of immediate learning;* • *potential for additional learning within your agency*

Advice on Submission of Rapid Reviews

Contact details for advice on the completion of this form and where the completed form should be submitted to:

Abigail McGarry - Tel: 01603 223335
NSCP Business Manager
abigail.mcgarry@norfolk.gov.uk

You may also wish to refer to You may also wish to refer to the NSCP's local guidance on SPRs and/or the National Child Safeguarding Review Panel's Practice Guidance

6. Template for recording Rapid Review Decision-Making

Norfolk Safeguarding Children Partnership

NB This section will be cut and pasted to the Rapid Review report for submission to the National Panel

Date:

List of Participants in Rapid Review:

Name	Job Role/Title	Agency/Organisation

Immediate Action

If further action is required to ensure that the child (ren) and any adult who may be at risk and who are affected by this review provide details of who will be responsible and how this will be communicated		
Action Required	**Responsible Officer**	**Deadline for action**

Identifying Improvements to Safeguard and Promote the Welfare of Children

SPRG has considered how best to learn from the case using the determinants listed in the table below.

Determinant	Notes
1 Highlights improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified, including any thematic learning	
2 Highlights concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children	
3 Analysed intersectionality, i.e. the interconnected relationship of social categorisation such as race, gender, sexual orientation together with unique vulnerability and adversities suffered by the individual	
4 Is one in which safeguarding partners have cause for concern about the actions of a single agency	
5 Is one where there have been gaps in agency involvement (or no involvement) and this gives the safeguarding partners cause for concern	
6 Is more than one local authority, police area or integrated care board is involved, including in cases where families have moved around	
7 May raise issues relating to safeguarding or promoting the welfare of children in custody or institutional settings	
8 Highlights good individual practice or agency service provision.	
9 Highlights other significant factors that may lead to learning or service improvement	
10 Has national implications and/or should be considered for a national CSPR?	

If there was significant disagreement on any of the above provide details

Rapid Review Decision

Give details of the action the partnership take as a result of the Rapid Review. • This may include commissioning a local child safeguarding practice review or another form of audit or review. • Explain the reasons for the decisions made: clearly state whether or not the case has met the criteria for a child safeguarding practice review • Provide details of any specialist advice provided, including legal advice. • Include a record of any disagreement with the approach adopted if any agency wishes that to be recorded. • SPRG may also ask the partnership or a member agency to take specific action.

Does this episode require review under other statutory guidance/NHS procedure? If so explain how the reviews will be combined or co-ordinated.

If proceeding to a child safeguarding practice review, please note any areas SPRG wishes to be included in the Terms of Reference for that review

Provide details of further consideration given to this decision by the Lead or Delegated Safeguarding Partners, if any:

If an SPR is *not* being commissioned detail any other learning options and log the name of the officer responsible for taking learning forward

ACTION LOG		
Further action	**Who is responsible**	**Date of completion**
Share information with Lead and Delegate Statutory Safeguarding Partners for any further discussion		
Provide feedback to referring agency, if applicable (local RRs only)		
Submit Rapid Review Report and record of decision-making to the National Panel		
Notify agencies involved of decision to proceed to CSPR, if applicable.		
Commission Lead Reviewer, if applicable.		

7. Commissioning an Independent Lead Reviewer

When a child safeguarding practice review has been commissioned, the NSCP will appoint one or more suitable individuals as Lead Reviewers. The Lead Reviewers should be independent of the organisations involved in the case

Prior to commission, the Lead Reviewer must demonstrate that they are qualified to conduct reviews. The NSCP has developed commissioning tools to support selection. At vetting, all Lead Reviewers are required to provide:

- contact details of two referees
- up-to-date CV, including previous experience of undertaking reviews
- details of any recent reviews conducted – ideally with links to published reports to review writing standards
- confirmation of public liability and professional indemnity insurance
- confirmation of registration with the Information Commissioner

Only high level information on cases will be shared with the Lead Reviewer at initial discussion. Detailed information will not be provided until the above has been provided and a contract agreed.

The NSCP offers clear guidance to reviewers, including a summary of any local strategies or initiatives which are relevant to the case. The Lead Reviewers are also encouraged to visit the NSCP website to view the resources and learning tools available in Norfolk.

Expectations of the Final Report

Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond, so the safeguarding partners must publish the report. The safeguarding partners must ensure the final report includes:

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

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

The name of the reviewers should be included on the final report. Published reports or information must be publicly available for at least one year.

When compiling and preparing to publish the report, the delegated safeguarding partners should consider carefully how best to manage the impact of the publication on children, family members, practitioners and others closely affected by the case. The safeguarding

partners should ensure that reports are written in such a way so that what is published avoids harming the welfare of any children or vulnerable adults involved in the case.

Depending on the nature and complexity of the case, the report should be completed and published as soon as possible with an aim to complete in six months from the date the National Panel have notified the NSCP that they support the review. Where other proceedings may have an impact on or delay publication, (for example, an ongoing criminal investigation, inquest or future prosecution), the safeguarding partners should inform the panel and the Secretary of State of the reasons for the delay. Safeguarding partners should also set out for the panel and the Secretary of State the justification for any decision not to publish either the full report or information relating to improvements. Safeguarding partners should have regard to any comments that the panel or the Secretary of State may make in respect of publication.

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

- capture points from the case about improvements needed
- take corrective action and disseminate learning

8. Involving Parents and Children in CSPRs

Family members are an important source of information about how services were experienced in an individual case and may provide information about service delivery in general. In this context, the definition of family can be broadened to include wider family and networks where this is judged to be necessary and proportionate to the likely learning. Publication of CSPRs places a greater onus on the Norfolk Safeguarding Children Partnership (NSCP) to ensure that personal data placed in the public domain is accurate and involving family members may facilitate this. However, it can be entirely appropriate for family members to decide not to take part.

Families will be notified in writing and by telephone when a CSPR is commissioned with a clear explanation of the process, i.e. it is about learning not apportioning blame and is an opportunity to better understand and improve safeguarding systems.

Family members will be offered the opportunity to speak directly with the independent Lead Reviewer as early in the process as possible, recognising potential constraints around any criminal investigations. Any evidence the family may wish to submit in terms of correspondence or other written records they hold of service interventions should be treated with equal weight as the evidence provided by agencies.

Children and/or siblings will be communicated to via their support networks and/or through their allocated social worker/suitable advocate. The Lead Reviewer will ensure that:

- The conversation is managed sensitively and in language that the child can understand and respond to
- Follow up care is arranged in the event that the meeting causes additional distress.

The Lead Reviewer will be accompanied by a note taker, usually the Head of NSCP Business Delivery, in order to record the meeting. Notes will be shared with the family member to check for factual accuracy. Should there be a criminal investigation any such notes will be subject to review by the police disclosure officer to ensure compliance with the Criminal Procedure & Investigations Act 1996

One or more meetings may need to be arranged to ensure that the family is recognized as a key stakeholder in drawing out the learning.

Prior to the meeting(s) consideration will be given to:

- Identifying the support needed to enable child involvement
- Additional support needed where there are issues of domestic abuse
- Clarity about confidentiality especially if there is fear of repercussions from wider family/network
- Addressing any contradictory views between family members - especially if there are expectations about a definitive account
- Engaging with the senior investigating officer so they get the focus and scope of the review in order to allow informed discussion about how and when families can be involved

The published reports will note:

- The purpose of family involvement, including which family members are involved and why
- How the analysis is informed by family members' knowledge and experiences relevant to the period under review

The family will be advised of the publication date in advance and sent a hard copy of the final report for their records.

If family members are not involved, the reasons for non-involvement will be noted in the report, e.g. they declined and/or were prohibited by parallel proceedings.

9. Roles and Responsibilities of CSPR Panel Members

The Norfolk partnership should be proud of its approach to learning and the culture of openness and transparency that has been evident in its case review processes. This is in large part down to the senior officers selected to sit on review panels and the clarity they have about their roles and responsibilities.

It is expected that officers will continue to contribute to creating safe learning environments for both the Panel as well as the professionals directly involved in the cases. The CSPR Panel members will:

- have sufficient seniority to be able to work at and represent all levels within their agency
- be independent of the case, i.e. have no direct line management responsibilities of any staff involved or any significant involvement in the case under review
- be familiar with current child protection practice
- provide all information requested by the Lead Reviewer within prescribed timescales and in accordance with national guidance
- have unrestricted rights of enquiry and access to staff within their agency, including relevant records and files
- ensure that all files relating to the child/the review are secured to ensure information is not lost
- ensure that the relevant staff in their agency are informed of the purpose of the child safeguarding practice review, and exercise their duty of care to staff involved, including:
    - communicating with them regarding expectations and their role in the process;
    - the methodology agreed; and
    - the opportunities available for them to contribute to the learning.
- participate in 1-2-1 meetings with any professional involved in the case, subject to methodology
- be fair in the way that the views of staff are represented
- advise the professionals involved, their agency and the Panel if any competency issues emerge as a result of the review and deal with this outside of the review process
- facilitate meetings with children and families, if appropriate to their role
- contribute to the analysis of practice and learning
- quality assure the draft reports prior to them being finalised for sign off
- share the final report with their agency chief officer before sign off

In some cases, the subject child and/or their siblings may remain open to Children's Services during the course of the review. It is imperative that any operational issues outside of the scope of the review are considered separately. The Panel members with ongoing involvement with the child/ren and their families are expected to resolve issues and/or escalate concerns through existing routes, e.g. the Joint Agency Group Supervision procedure. If the Lead Reviewer identifies serious concerns that the child's safety continues to be compromised, they should first raise this with the relevant panel members, but if this does not lead to a timely resolution, the Lead Reviewer should inform the relevant Statutory Partner(s) in writing. The Lead Reviewer is entitled to ask about and comment on current case management in the final report.

10. Sign off and Publication

Child Safeguarding Practice Review (CSPR) Report Sign Off

The process for signing off CSPRs prior to publication involves four steps:

1. CSPR Panel agrees report is complete and reflects Panel discussions, prior to going to SPRG
2. SPRG agrees final report for sign off by the Delegate Safeguarding Partners
3. The Delegated Safeguarding Partners sign off at a discrete meeting
4. NSCP's wider Partnership Group signs off the report at its bi-monthly meeting

NB The NSCP is led by the three statutory partners, i.e. the Local Authority, the Police and Health, but the bi-monthly Partnership Group meetings also include strategic leaders from other areas of the partnership. When a CSPR is scheduled for sign off the head of any agency involved in the review or a suitable delegate (typically the representative at Partnership Group) will be invited to attend that meeting and agree the report prior to publication. This will include any partners from out of county where appropriate, unless otherwise agreed by that LSCP.

CSPR Report Publication

Child Safeguarding Practice Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond. *Working Together 2023* requires local safeguarding partners to publish the final reports, unless they consider it inappropriate to do so. In such a circumstance, the 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 will be publicly available on the NSCP website for a minimum of 12 months.

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

The Head of NSCP Business Delivery is responsible for sending a copy of the full report to the Panel and to the Secretary of State no later than seven working days before the date of publication. Where the safeguarding partners decide only to publish information relating to the improvements to be made following the review, the Head of NSCP Business Delivery will also provide a copy of that information to the National Panel, the Secretary of State and Ofsted within the same timescale.

Norfolk County Council is the lead partner managing press statements, collaborating with relevant partner agencies' communication officers. A separate briefing for Children's Services Lead Member is also prepared and issued by the Head of NSCP Business Delivery prior to publication.

A template 12-step publication plan is included below to ensure that communication systems are in place throughout the publication process.

PUBLICATION PLAN – TEMPLATE

ACTION		DATE	Who
1	Final QA of report: • check watermarks • include NSCP logo on front page • check whether judicial agreement is required from Family Court		
2	Summary learning PowerPoint developed and agreed at SPRG		
3	Meeting with NCC comms & press statement/strategy drafted		
4	Head of NSCP Business Delivery prepares briefing for senior responsible officers, i.e. • Leader of Norfolk County Council • Children's Services Lead member • Chief Officers of the three statutory partners		
5	NSCP Press statement shared with comms partners from all agencies involved in the case		
6	Advise family of report publication date and meeting arranged pre-publication		
7	Advise Lead Reviewer and Panel of publication date		
8	Send report only to National Panel/Ofsted with proposed publication date allowing at least five working days before publication		
9	Forward final report and PowerPoint to: • SPRG & NSCP • CSPR Panel & Lead Reviewer Advise that the report is embargoed until publication date and to let professionals involved in CSPR know of publication date Ensure that any SWs or other professionals currently working with the families are aware		
10	Write to parents/children and send them a copy of the published report		
11	Post report and summary PowerPoint on website to meet publication date		
	Write to relevant LSCPs about report for their learning (if applicable – may include earlier depending on involvement)		
12	Send link to report and notice of publication to: • The NSCP wider partnership • SPRG • CSPR Panel & Lead Reviewers • Case Groups/professionals who participated in review • Coroner and CDOP (if applicable) • Safer trainers • In-Trac (NSCP Multi-Agency training provider) • Other interested parties, e.g. CDOP, Trading Standards etc		

11. Dissemination of Learning Options

The NSCP will build on current processes to support the dissemination process. Options that have been used or could be developed in the future are included below:

Options for Disseminating Learning	Rationale
Summary learning PowerPoint, published alongside full reports	Feedback from frontline indicates that this format is useful, particularly in team meetings
CSPR roadshows	Reach into frontline and evidence of positive feedback from evaluation and raises profile of NSCP
Best Practice Events	Ability to hone in on specific safeguarding issues
Conferences	Supports strategy development on specific issues, e.g. CSA, and raises awareness
Used in training – shared with: • NSCP Workforce Development Group, • single & multi-agency training providers and • Safer trainers	Ensures training material is local and focusing on improving practice linked to learning
Films	Enables voice of children, families and frontline to be heard in different format
Webinars – discussion with Lead Reviewer and NSCP Partners on specific cases	Wider reach and interactive format
Leadership Learning Events	SPR methodology demonstrated this is a powerful way to ensure strategic leaders are included in learning/review process
Incorporated into NSCP Business Plan and relevant strategies	Specific and/or thematic recommendations tracked through to business delivery and strategy implementation
Section 11	Single agencies will be asked to account for how they have disseminated and implemented any learning through the S11 self assessment process