Rapid Review & Child Safeguarding Practice Review

Overview Process Flowchart

Where a local authority knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel (National Panel):

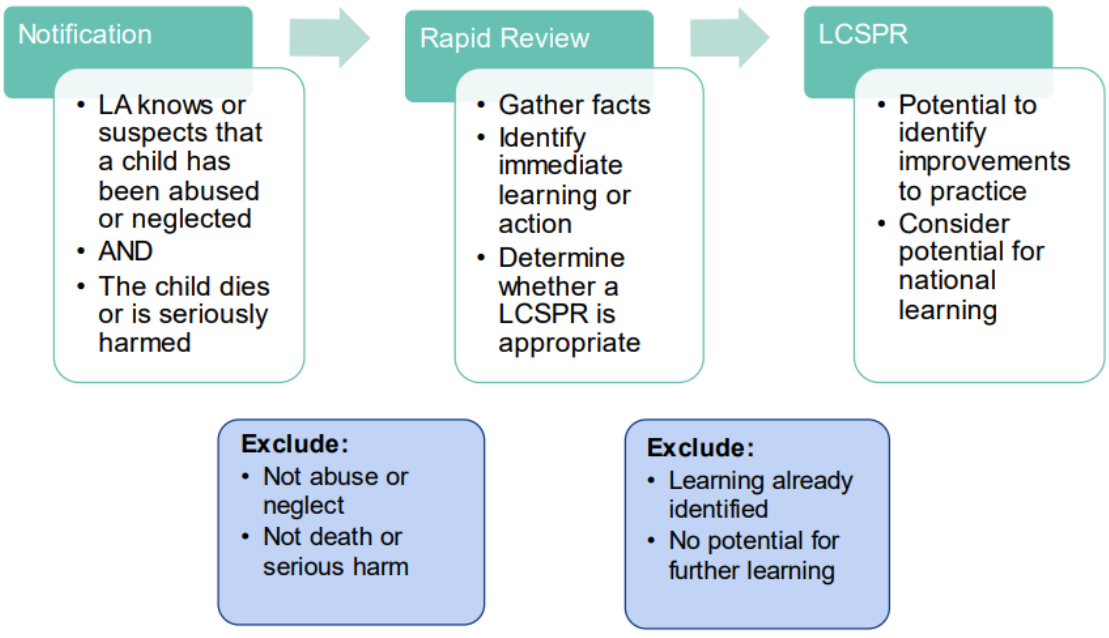
- if a child dies or is seriously harmed and abuse or neglect is known or suspected
    - in their area
    - outside of England, but they're normally resident in their area
- to report the death of children looked after by a local authority whether or not abuse or neglect is known or suspected

Please note: In the event of a child death there is a separate process that is undertaken by the Child Death Team and runs in parallel with the Rapid Review. In such a case the following online form must also be completed within 24 hours Surrey eCDOP Notification Form A

The National Panel are independent and commission national reviews of serious child safeguarding cases. Their criteria is for national and local reviews to focus on improving learning, professional practice and outcomes for children.

As outlined in Working Together 2023 there are 3 stages in the process of learning from serious cases: Serious Incident **Notification** (SIN), **Rapid Review** and **Local Child Safeguarding Practice Review** (see figure 1 below).

Figure 1: Decision making around reviews

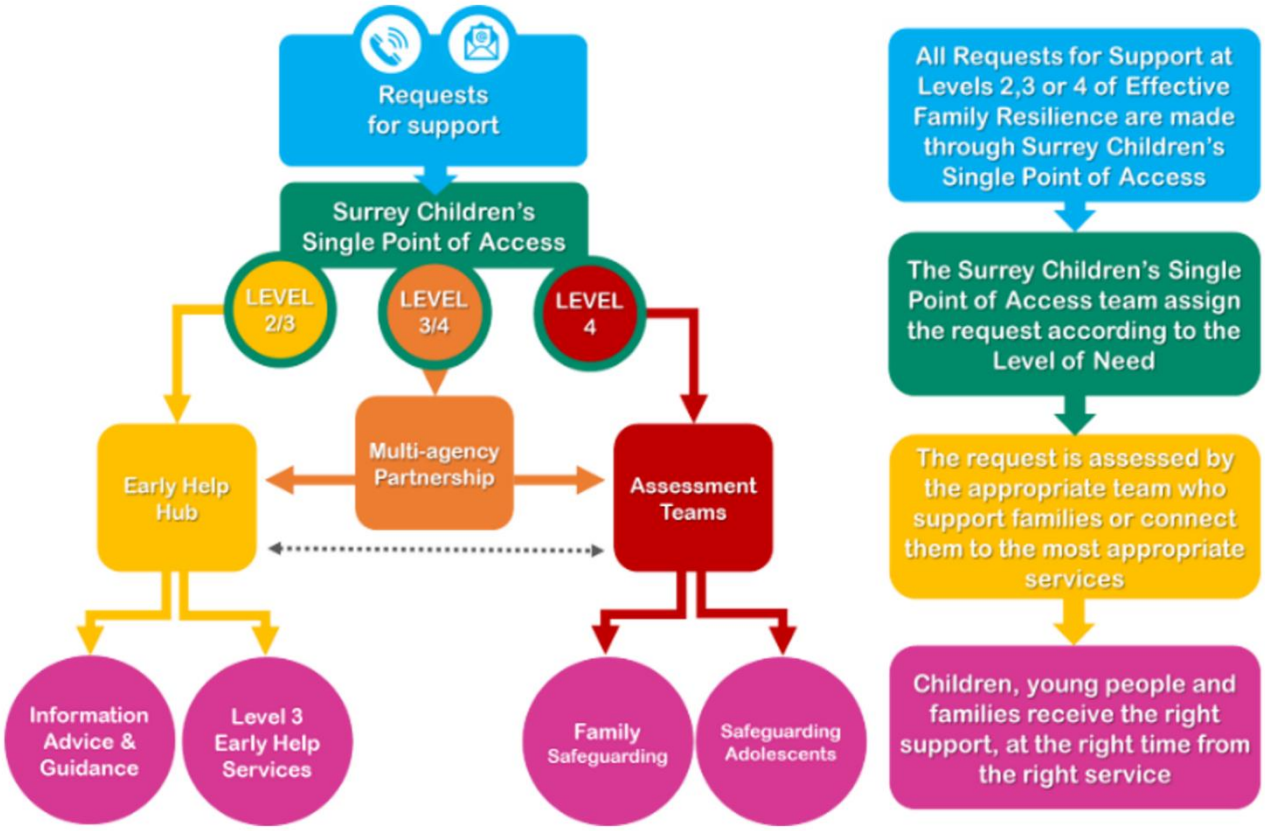


This flowchart below shows how the Request for Support (RFS) form is triaged <u>prior</u> to a possible Serious Incident Notification.

*Please note: a RFS form can be specifically used to raise a concern around a serious incident **as well as** seeking support/services for a child not already known to Surrey.*

A child already known by Children Services will be escalated using a Cause for Concern form completed by the Assistant Director in the relevant quadrant.

If either of these result in a Serious Incident Notification (SIN) it will trigger the Rapid Review and Local Child Safeguarding Practice Review process (shown on the page below).



Rapid Review (RR) and Local Child Safeguarding Practice Review (LCSPR) Process

Day 1

- Serious Incident Notification Form used to notify the National Panel **within 5 working days** of the Local Authority being aware of the incident
- Date for Rapid Review Panel (Case Review Group) meeting set
- Request for completion of Initial Scoping & Info Sharing document sent to all agencies

Within 5 working days of notification

- Initial scoping forms returned to Partnership team for collation onto a master document which is sent to the Rapid Review Panel at least 48 hours before the Rapid Review meeting.

Day 9 - 10

Rapid Review meeting held to

- Gather facts
- Identify immediate learning or action
- Determine whether a LCSPR is appropriate, identify Agency Chair and Panel members

Day 10 - 11

Draft Rapid Review Outcome Report written and sent to Panel Chair, Legal representative and Partnership Development Manager for comments **within 48 hours**

Day 12 - 13

Final draft Rapid Review Outcome Report sent to the SSCP Chair and the Exec for approval **within 48 hours**

By Day 15

Rapid Review Outcome Report sent to National Panel recommending an LCSPR if appropriate

LCSPR recommended?

YES

Plan key date timeline to complete within 6 months

Develop 7 minute briefing with initial learning

Commission Lead Reviewer

NO

Share learning from rapid review (thematic, local or national)

Develop 7 minute briefing

Local Child Safeguarding Practice Review (LCSPR) Process is recommended:

Within 6 months

At the end of the Rapid Review meeting, it is agreed which Agency will provide the LCSPR Chair and which members will make up the Case Review Panel (CRP). 3 - 4 lines of enquiry are also drafted.

An Independent Lead Reviewer is commissioned to review the case and write a report which will be submitted to the National Panel within 6 months.

<u>Information requests/forms to be completed</u>

When a Child Safeguarding Practice Review is commissioned, all relevant agencies will be asked to complete an Information Management Report (IMR) along with chronologies of their agency's involvement in the case and any organisational changes that took place within the time period being examined. This will be required within 4 weeks. The IMR is designed to analyse the agency's involvement with the child and family and any themes that have emerged.
The aim is to:

- Identify improvements to practice
- Consider potential for national and/or local learning

<u>Meetings and Events to attend</u>

There are usually 3 – 4 Panel meetings which authors of IMRs may be asked to attend.

<u>Family</u>

The family will be informed at the outset by a member of the Child Death Review (CDR) Team or Children's Social Care Team that an LCSPR is being undertaken and kept up to date with the process. The family will be invited and encouraged to share their experience with the Lead Reviewer in order for their views and opinions to be reflected.

<u>Final Report</u>

Following agreement by the Panel, approval from SSCP Case Review sub-group and SSCP Executive the report will be sent to the National Panel and then published on the SSCP website.

<u>Learning</u>

The Learning from Practice sub-group will disseminate learning across the Partnership via 7-minute briefings, lunch and learn sessions or SSCP briefings. Any learning emerging during the course of the review will already have been actioned by involved agencies.

The Annual Report 2021 from the National Panel identified six key practice themes from reviews nationally which could make a difference to safeguarding practice:

Post Final Report

1. Supporting critical thinking and professional challenge through effective leadership and culture
2. The importance of a whole family approach to risk assessment and support
3. Giving central consideration to racial, ethnic and cultural identity and impact on the lived experience of children and families
4. Recognising and responding to the vulnerability of babies
5. Domestic abuse and harm to children – working across services
6. Keeping a focus on risks outside the family

Useful links:

National Panel (Child Safeguarding Practice Review Panel) 2021 - annual report (publishing.service.gov.uk)

Working Together 2023

NSPCC case reviews

Child Deaths - Surrey Safeguarding Children Partnership (surreyscp.org.uk)