One minute guide

Serious Child Safeguarding Incidents and Reviews

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What is a Serious Child Safeguarding Incident; what reviews are needed and when?

A Serious Child Safeguarding Incident (SCSI) is where a child has died or been seriously harmed, and abuse or neglect is known or suspected within the local authority area, or involving a child who is normally resident in the local authority's area but the incident has occurred elsewhere.

The LSCP Review Advisory Group (RAG) will then come together to discuss details of the case and decide if the SCSI requires a notification to the National Child Safeguarding Practice Review Panel. If notification is required then the RAG must also notify the local safeguarding statutory partners (local authority, health and police). In Leeds, this is the Leeds Safeguarding Children Partnership (LSCP) Executive.

Rapid Review - Following the notification of a SCSI to the National Child Safeguarding Panel and the statutory partners, there is a requirement for the statutory partners to undertake a Rapid Review within 15 working days of the notification. A Rapid Review is a multi-agency process which considers the circumstances of a SCSI. The purpose of the Rapid Review is to identify and act upon any immediate learning, and consider if there is additional learning which could be identified through a wider local Child Safeguarding Practice Review (CSPR).

Child Safeguarding Practice Review (CSPR) - If the Rapid Review identifies that there is further learning from a particular incident which has not been fully identified and explored through the Rapid Review, the LSCP must commission a Child Safeguarding Practice Review (CSPR). The purpose of a CSPR is to explore how practice can be improved through changes to the system itself.

The final decision with regards to initiating a CSPR lies with the LSCP Executive.

Why do we have Rapid Reviews and CSPRs?

The purpose of Rapid Reviews and CSPRs is to identify lessons that require improvements to be made to policies, procedures and practice. Reviews are not ends in themselves; lessons must be used to improve practice, manage risks better and enhance outcomes for children and young people. The reviews focus on systems and how agencies work together to safeguard children and young people rather than aiming to hold individuals to account.

In Leeds, how is learning from reviews disseminated?

All identified learning from a review is disseminated to practitioners in a number of different ways including through briefings, inclusion within training, and the LSCP website. Agencies are asked to ensure that learning is widely disseminated within their agencies.

What happens when a Rapid Review is carried out?

Partner agencies will be asked to provide information they have with regards to their interactions with the child and their family - and specifically in relation to the SCSI - and attend a joint meeting with the RAG. Discussions in this meeting as well as the information provided will be considered by the LSCP Review Advisory Group (RAG), which will allow them to consider learning and make a recommendation as to whether or not further learning would be identified through a CSPR. The final decision with regards to initiating a CSPR lies with the LSCP Executive.

The LSCP must notify the National Child Safeguarding Panel of the outcome of the Rapid Review within the 15 working day timeframe.

What happens when a CSPR is carried out?

Safeguarding Children Partnerships have autonomy on how they undertake a review, although there is guidance as to what a review should consider and what is included within the final report. A review is written by an independent author who has had no involvement in the case or the agencies who are taking part in the review. A review panel would normally support the review process and would be made up of representatives from the agencies who had involvement with the child and/ or families the review is focusing on.

Safeguarding Children Partnerships have a duty to publish completed reviews on their websites and the NSPCC Repository, unless publication is considered a further safeguarding risk to the child or other family members. This is done anonymously in order to ensure confidentiality.

Practitioners are invited to be part of the review, often through learning days known as a Practitioner Events. These allow practitioners to explore the learning from the review and consider actions or changes in practice based upon their experience as practitioners working directly with children, young people and families.

Families - and, where appropriate, children - are also invited to be part of the review process. They are informed of the review as it is commissioned and will be asked to contribute as the review progresses. The review will also be shared with them at the end of the process, prior to publication.

Once a review is complete and learning has been identified, an action plan is developed in conjunction with the agencies who took part in the review. This is to identify how the learning will be translated into changes in practice.

For more information

The LSCP website provides information about all multi-agency review processes in Leeds and the learning from multi-agency reviews.

The NSPCC website hosts the national repository for CSPRs (and the reviews which were previously known as Serious Case Reviews).

The National Child Practice Safeguarding Review Panel publish an annual report as well as undertaking national reviews based on recurring themes.