BARNSLEY SAFEGUARDING
CHILDREN PARTNERSHIP

Barnsley Child Safeguarding

Practice Review

Guidance

This toolkit provides professionals with a step-by-step guide to follow when undertaking or participating in a Local Child Safeguarding Practice Review.

It describes the approach, order of events and related timescales whilst also highlighting the key statutory elements outlined in ***Working Together to Safeguard Children 2026***.

It also outlines responsibilities for key people at every stage of the process and provides links to good practice guides and templates.

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Version 1.0	April 2026
Version 2.0	

1. Who Is the Toolkit and Guidance For?

1.1 This toolkit and guidance was produced on behalf of the Safeguarding Partners, and agencies involved in Multi-Agency Safeguarding Arrangements. The guidance is aimed at those specifically involved in commissioning, managing or contributing to Rapid Reviews (RR), Local Child Safeguarding Practice Reviews (LCSPR) and Lower- Level Reviews also known as Local Learning Lessons Reviews (LLLR), as well as those responsible for quality assuring and embedding the learning from the review process.

2. Introduction

2.1 The role of Barnsley Safeguarding Children Partnership (BSCP) is to support children and their families to feel safe, and to live free from abuse and neglect. Statutory partners endeavour to learn from any incidents by gathering and sharing learning from individual cases to continuously improve single agency practice and multi-agency working in order to improve outcomes for children and families in Barnsley and prevent future occurrences.

2.2 This document sets out Barnsley's approach for reviewing single and multi-agency practice to safeguard children. It has been designed to incorporate the statutory criteria for conducting safeguarding practice reviews set out in Working together to safeguard children 2026: statutory guidance and Child Safeguarding Practice Review Panel: guidance for safeguarding partners

2.3 The Children and Social Work Act 2017 introduced a new legal framework in respect of local safeguarding arrangements for children. Responsibility for how a system learns lessons from serious child safeguarding incidents now rests at a national level with the Child Safeguarding Practice Review Panel (the National Panel) and at a local level with the three Safeguarding Partners (Integrated Care Boards, Police and Local Authorities).

2.4 Local areas are required to conduct a Rapid Review whenever a child has died or been seriously harmed and abuse or neglect is known or suspected. This Rapid Review should allow the Safeguarding Partners to consider the potential for learning and to decide whether it meets the criteria for a Local Child Safeguarding Practice Review (LCSPR).

2.5 Where it meets the criteria any further review of a case will be referred to as a Local Child Safeguarding Practice Review and should meet the requirements of a LCSPR. **There are no other types of review needed or allowed within Working Together 2026**. Local areas may also choose to undertake a LCSPR in other circumstances where they feel learning may be identified. In Barnsley these will be known as Local Learning Lessons Reviews (LLR)

2.6 The purpose of this guidance is to:

a) Set out the referral and decision-making arrangements for all learning reviews. This includes guidance on good practice and decision-making, and has been developed to simplify and clarify local processes by:

- Providing an overview of how to notify serious incidents/cases which may be suitable for review.
- Enabling a consistent approach to decision making.
- Demonstrating how local processes comply with legal requirements and best practice.
- Clarifying timeframes in line with legislation and statutory guidance.
- Clarifying local roles and responsibilities in regard to referral/notification and decision making.
- Providing transparency about the decision-making process.

- Supporting planning and preparation for reviews.

b) Set out how reviews will be managed and monitored by BSCP, and how information is shared between relevant sub-groups and the wider safeguarding partners.

c) Provide a comprehensive toolkit of specific guidance and practical resources to assist in conducting effective reviews. A toolkit contents list is provided separately

3. Purpose of Child Safeguarding Practice Reviews

3.1 The purpose of child safeguarding case reviews, at local and national level, is to identify improvements that can be made to safeguard and promote the welfare of children. Learning is relevant locally but has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.

3.2 Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations, or agencies to account, as there are other processes for that purpose, including employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings.

> 'Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. Safeguarding partners and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.'

4. Definition of a Serious Child Safeguarding Case

4.1 Working Together 2026 requires the three statutory safeguarding partners to consider whether to conduct a Rapid Review, which may result in a Local Child Safeguarding Practice Review (LCSPR) in serious child safeguarding cases.

4.2 Working Together 2026 and Guidance from the Child Safeguarding Practice Review Panel defines serious child safeguarding cases as those in which: abuse or neglect of a child is known or suspected, and the child has died or been seriously harmed.

4.3 Serious harm includes (but is not limited to) impairment of physical health and serious / long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development

4.4 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.

4.5 Working Together 2026 also sets out that some cases may not meet the definition of a 'serious child safeguarding case' but nevertheless raises issues of importance to the local area. This may, for example, include examples of good practice, poor practice or 'near miss' events. Safeguarding partners may choose to undertake a local CSPR in these or other relevant circumstances.

5. Responsibility for reviews

5.1 The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel (national panel) and at a local level with the safeguarding partners.

5.2 The national panel is responsible for identifying and overseeing the review of serious child safeguarding cases which, in its opinion, raise issues that are complex or of national importance. It should also oversee the system of national and local reviews and how effectively it is operating.

5.3 The safeguarding partners play an integral role in establishing a system of learning and reflection locally. Safeguarding partners must:

- Identify and review serious child safeguarding cases which, in their opinion, raise issues of importance in relation to their area
- Commission and oversee the review of those cases if they consider it appropriate
- Have accountability for ensuring learning from serious incidents is implemented, is the responsibility of the LSPs and the impact of local and national reviews should be evidenced in yearly reports and subjected to independent scrutiny.

5.4 The national panel and safeguarding partners have a shared aim to identify improvements to practice for protecting children from harm and should maintain an open and ongoing dialogue. This will enable them to raise concerns, highlight commonly recurring areas needing further investigation (whether leading to a local or national review), and share learning, including from success, that could lead to improvements elsewhere.

5.5 Safeguarding partners should have regard to any guidance the panel publishes such as Child Safeguarding Practice Review Panel: guidance for safeguarding partners)

6. Strategic Leadership and Governance

6.1 The BSCPs Operational and Business Group is responsible for overseeing the multi-agency processes for conducting reviews of every serious child safeguarding case including Rapid Reviews and LCSPRs and will be responsible for requesting single agency assurances in response to safeguarding incidents or concerns.

6.2 The partnership will also consider alternative reviews that will provide significant insight into new systems or practice issues and explore the role of other types of reviews

6.3 Overall responsibility and overseeing the recommendations and learning from Barnsley's rapid reviews and Local Child Safeguarding Practice Reviews including other national and local reviews, is the responsibility of the Operational and Business Group, supported with our enabling audit and performance sub group to ensure progress is being made, and that any learning is shared across the partnership.

6.4 Governance arrangements between the BSCP Executive group and Operational and Business Group are managed through quarterly updates. The Delegated Safeguarding Partners (DSP's) is the executive lead ultimately responsible for the decision-making and oversight. This includes conduct of statutory learning reviews, quality assurance, sign off and publication of final reports.

6.5 As part of the robust governance processes, escalation processes are in place to enable any of the BSCP subgroups to flag up issues with the BSCP Executive group. Where the process

is not operating effectively at any level, partners are not engaging or providing adequate information as required, or if there is a pattern of behaviours that are impacting on the effectiveness of functions, escalation will initially be through the chair of Operational and Business subgroup for resolution and then to the partnership DSP's. If continued resolution is required, it can be further escalated to the Lead Safeguarding Partners.

6.6 The three statutory partners at the strategic level are ultimately accountable for decision making and assurance that any delegated powers and multi-agency safeguarding arrangements are functioning effectively.

7. Principles and Values

7.1 BCSP's approach to reviewing practice is underpinned by the following principles:

- **Person centred:** The individual (where able) and their family, carers or others as appropriate will be invited and supported to contribute purposefully to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- **Think Whole Family:** The whole process will reflect a 'think whole family' approach where thought is given to the family/friend network and professional system. This will inform who needs to be included in any review; key lines of enquiry and resulting learning.
- **Enable Change:** All reviews will provide learning back into the system, designed to improve the way services are provided, not simply describe or challenge it, and the process should illuminate barriers and enablers to practice.
- **A culture of continuous learning and improvement:** will be promoted across agencies that work together to safeguard the wellbeing of children and adults, identifying opportunities to draw upon what works and to promote good practice.
- **Embedding learning:** Individual agencies will be responsible for identifying and addressing issues early, pro-actively and pre-emptively analysing and learning from individual cases.
- **Proportionate:** The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.
- **Independent scrutiny:** Reviews should be led by individuals who are independent (i.e. no direct line management) of the child under review.
- **Timely response:** Reviews should be completed in a timely manner unless there is a reason for a longer period, e.g. on-going criminal proceedings.

7.2 The agreed values that underpin BCSP's approach to reviews are:

- **Participative and collaborative:** We will seek to obtain the voice and experience of children/young people, and their families/carers where appropriate so that their views inform our understanding and learning.

  When a child dies or is seriously injured, this can be a professional challenge for the practitioners directly involved in supporting them and keeping them safe. BCSP is committed to conducting the reviews in a strengths-based way ensuring that the experience of practitioners involved with the family at the relevant time, have the opportunity to hear what might have supported best practice, and be given opportunity to participate in helping the partnership reflect and agree what changes would be effective.
- **Transparent**: Organisations will share all relevant information, and they and their staff will engage in the process in an open and reflective way to support learning and improvement.

- **Curious:** We will provide high challenge and high support to each other and our multiagency working. We are committed to a culture of improvement and learning which is relationship based and builds on strengths within agencies, individuals, families and communities.
- **Respectful:** Each individual's case record belongs to them. We will demonstrate our respect in the way we share and record information and provide feedback to staff. We have a duty to report with accuracy and understand that inaccurate recording of information in any form is detrimental to outcomes for children and other individuals.

8. Identity and culture

8.1 BCSP embraces diversity, equity, and inclusion so that our strategies and the work we do recognises and relates to every individual fairly. We evidence that all people in Barnsley are safe and well and that action is taken to address any inequality where it exists. Identity and culture are therefore significant elements of practice reviews.

8.2 All stages of the review process will explicitly consider:

- Individual vulnerability and adversities.
- Intersectionality (how the interconnectedness of social characteristics and cultural background of a child and their family may have impacted on their daily lived experiences including life chances, disadvantage, and discrimination).
- How the social characteristics and cultural background of a child and their family may have impacted on their access to services and/or the responsiveness of services in understanding and meeting individual need.
- How the social characteristics and cultural background of a child and their family may have impacted on professional decision making.

8.3 The BSCP referral/notification form for a LCSP/Case Review will request information about the characteristics of a child's identity e.g. sexual orientation, gender, ethnicity or disability and it is imperative that this information is provided where known. If the referrer has identified specific issues in relation to how the characteristics have or may have impacted on the child being exposed to serious harm; this should be set out in the notification form.

8.4 Where a decision is made to conduct a Rapid Review or subsequently a LCSPR/LLLR, there will be explicit consideration as to how any issues of identity and culture will be integrated into the key lines of enquiry and addressed through the review process.

9. Involvement of children, adults and family

9.1 All reviews should reflect the child's perspective and the family context. This does not require a descriptive account of all events; the aim is to provide appropriate and meaningful context, sufficient to illuminate the major theme or themes arising from the case.

9.2 Likewise, the lived experience of a child and where possible and appropriate, their voice, should be dominant throughout a review. LCSPRs should specifically consider these aspects in their analysis of the circumstances of the case, their appraisal of practice, and in the methods applied to the review.

9.3 Involvement of family members and other support networks can offer a unique perspective into how the delivery of services and involvement of agencies were viewed and responded to.

As a minimum, family members should:

- Be notified of the review process, what that means for them
- Agree the level and frequency of contact with family members to ensure they are kept informed.
- Be supported to contribute to the review process – either in writing, by meeting with the review authors, sharing views via a third party or by other means identified.
- Be included in feedback about the learning identified by the author.
- Be informed and prepared for the publication of the report in a timely manner
- Be provided with a read only copy of the report which family members can review and comment on prior to publication but not retain; where possible any relevant comments should be incorporated into the final version – A 'hard' copy of the report should not be provided until the report is in the public domain.
- When family are unable to contribute to the report – for example for legal reasons – the report must make clear the reasons for not including the family.

9.4 Contact with the family should be made through existing trusted professionals where possible, the Lead Reviewer or where appropriate - an advocate.

9.5 The lead contact must ensure that the sharing of information is proportionate and relevant, and that the focus for involvement. More detailed guidance about the involvement of children, adults and family members in reviews is included in the toolkit.

10. Information Sharing

10.1 Information sharing is essential in safeguarding and promoting the welfare of children. Learning from reviews highlights the need for professionals to share information of risk factors in a timely way to promote welfare and to prevent serious harm or neglect.

10.2 Effective practice reviews are equally dependent on all partners sharing the information they hold about a case and the associated professional practice to identify relevant learning.

10.3 Working Together to Safeguard Children 2026 provides the legal framework for requesting and sharing information held by partners about an individual and any associated professional practice.

10.4 Data sharing requirements for statutory child practice reviews applies to all agencies and relevant information should be provided within the timescale requested.

10.5 The three statutory partners also have the power to take legal action if information is withheld without good reason, as a last resort.

10.6 The collection of information will be proportionate and requests for data about others associated with the subject of the review will only be made after having first considered their human rights, including their right to a private life.

10.7 Information about associated individuals will only be requested where this is essential in order to carry out the statutory requirements for the review and is considered to be in the public interest.

10.8 Further guidance can be found in BCSP information sharing protocol.

10.9 The BCSP Business Unit will ensure that information shared is GDPR compliant before being securely circulated with review papers to partners.

10.10 Good practice principles around information sharing will apply, particularly around 'how' information is shared. When responding to requests for information, agencies should:

- Identify how much information to share.
- Distinguish fact from opinion.
- Ensure that they give the right information to the right individual.
- Ensure that they share information securely.
- Where possible, be transparent with the individual, informing them that that the information has been shared (as long as doing so does not create or increase the risk of harm).

10.11 Record all information sharing decisions and reasons in line with organisational procedures. In the case of any disagreement or failure to comply with a formal information request, the BCSP Partnership Manager will raise the issue with the chair of the panel who will seek to resolve this with the strategic safeguarding lead for the agency concerned. If a prompt resolution cannot be found, the issue will be escalated to the DSPs for formal action.

11. Making a Serious Incident Notification (SIN)

11.1 The local authority has a duty to notify the National Panel within five working days where it knows or suspects that a child has been abused or neglected and

- The child dies or is seriously harmed in the local authority's area, OR
- While normally resident in the local authority's area, the child dies or is seriously harmed outside.

11.2 The local authority should also notify the Secretary of State for Education and Ofsted where:

- a Looked After Child has died, whether or not abuse or neglect is known or suspected.
- the death of a care leaver up to and including the age of 24

11.3 The death of a care leaver does not require a rapid review or local child safeguarding practice review. However, safeguarding partners must consider whether the criteria for a serious incident have been met and respond accordingly

11.4 All three statutory safeguarding partners share equal responsibility for deciding whether an incident meets the threshold for notification and for providing relevant information. Where there is disagreement, partners should seek advice from the Independent Scrutineer and, where necessary, follow their own locally agreed dispute resolution processes. All notifications to the national panel must have final oversight and approval from the Executive Director of Children's Services before submission.

11.5 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 safeguarding lead to reach an agreement whether or not to notify. Guidance on whether to notify an incident is included in Referral for a LCSP/Case Review

12. Is it Abuse or Neglect?

12.1 The first two considerations in deciding whether to make a notification are

a) whether a child has died or been seriously harmed and
b) whether or not abuse or neglect is known or suspected, using the definition set out in Working Together 2026.

12.2 Notifications must always be made if abuse or neglect is known or suspected to be a cause of, or a contributory factor to, the death or serious harm of a child.

12.3 The question of whether or not abuse or neglect was known or suspected causes some difficulties for safeguarding partners. In essence we interpret this as meaning that there was sufficient reason to suspect that abuse or neglect was present and, at least in some way, caused or contributed to the death or serious harm.

If the event is in itself abusive, for example the child was murdered by a parent or carer, we believe the criteria would have been met, regardless of whether or not there was pre-existing evidence of abuse or neglect.

12.4 The local authority does not need to wait until abuse, or neglect is proven to make a notification; it is for local areas to determine which cases should be submitted to the Panel based on local and contextual understanding.

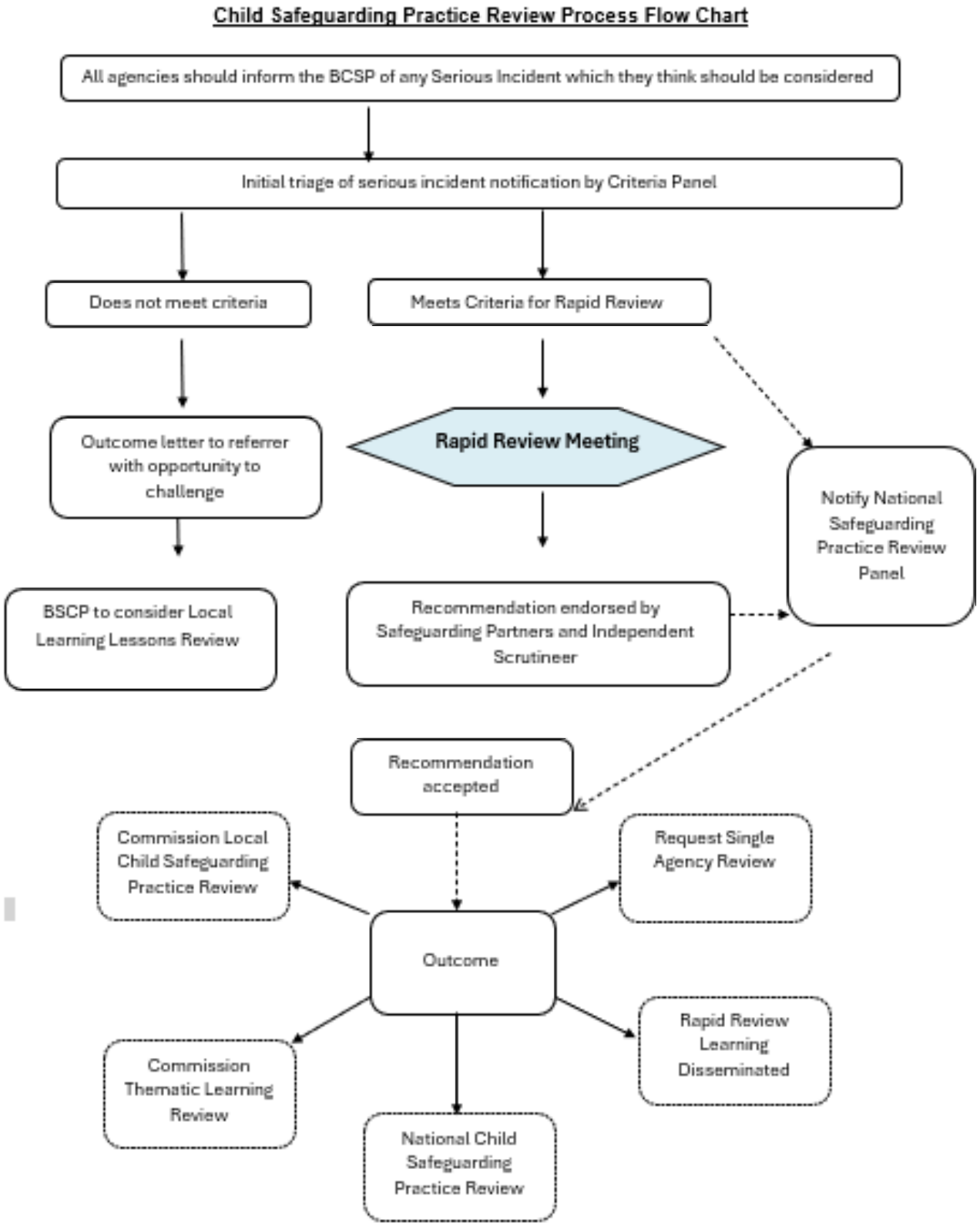
13. Is it serious?

13.1 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 practitioners use their professional judgement to determine whether the harm is serious.

13.2 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.

13.3 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 long-term impact.

14. Barnsley Child Safeguarding Practice Review Decision-Making Pathway



15. Referring a case for consideration of Rapid Review or Lower-Level Review

15.1 To support all partners to recognise and refer cases the BSCP has developed a single case referral form Referral for a LCSP/Case Review. This form allows partners to outline the case and propose the process they feel is required. The options are as follows:

1. A Rapid Review – potentially leading to a Local Child Safeguarding Practice Review
2. A Lower-Level review (e.g. Local Learning Lessons Review) – potentially leading to a multi or single agency learning process

15.2 All safeguarding partners and relevant agencies should ensure that their staff know about child safeguarding practice reviews, their purpose and function and how to make a notification through their organisation.

15.3 When deciding on which option to select your decision should be based on the guidance and definitions provided by Working Together 2026 and the Child Safeguarding Practice Review Panel: guidance for safeguarding partners 2025 in relation to serious harm and notifiable incidents.

15.4 The notification form should be submitted within 24 hours of becoming aware of any serious incident that referring agencies may consider meets the criteria for a Rapid Review/ Child safeguarding practice review and be submitted via secure email to: BarnsleySafeguardingChildrensPartnership@barnsley.gov.uk

15.5 The referring organisation should ensure that all notifications are quality assured and endorsed by the responsible safeguarding lead for their organisation.

16. Triage Panel

16.1 All cases submitted for Rapid Review or Lower-Level Review will receive an initial triage within 2 working days by the Partnership Business Manager including representation from the three statutory partners nominated representatives, and other appropriate panel members if required (i.e. independent scrutineer)

16.2 The aim of the Triage Panel is to consider the SIN notification in order to:

- Ensure the notification includes all the key information and enough detail to understand the concern(s) and agree any additional information that is required from the person making the notification or other key agencies for clarification.
- Determine whether any immediate actions are required to safeguard the child/ surviving siblings, or any other individual associated with the case and communicate this to the relevant agency.
- Agree whether there is reasonable cause to feel that the case may meet eligibility for a Rapid Review, i.e. that it meets the definition of a serious child safeguarding incident as defined in Working Together to Safeguard Children 2026 or is a case that will provide significant insight into a new system or practice issue.

16.3 If the decision is that the notification does not meet the criteria for a Rapid Review, then other proportionate learning reviews on a single or multi-agency basis may be considered at this stage if a multi-agency review is not required AND thresholds are not met.

16.4 If the case meets the criteria for a serious child safeguarding incident or statutory partners have determined that it is a case that will provide significant insight into a new system or practice issue, the triage panel will:

- Commence activities to complete a Rapid Review within 15 working days of notification.
- Produce an outline of the emerging key lines of enquiry from the notification and identify

any specific practice or systems issues to focus on as part of the Rapid Review.

- Agree which agencies should be involved in the Rapid Review.
- Agree the time period that the single agency chronologies need to cover.
- Consider whether and how to inform families of the notification.

16.5 A record of the outcome of the Triage Criteria Panel will be made by the BCSP Business Unit within the section within the notification form. This will provide a rationale as to why the case was determined to meet/not meet the criteria to progress to a Rapid Review and to notify National Panel.

16.6 All three statutory safeguarding partners share equal responsibility for deciding whether an incident meets the threshold for notification and for providing relevant information. Where there is disagreement, partners should seek advice from the Independent Scrutineer (*The Independent Scrutineer's views are advisory and do not replace partner responsibility) and*, where necessary, follow their own locally agreed dispute resolution processes. All notifications to the national panel must have final oversight and approval from the Executive Director of Children's Services before submission.

16.7 The outcome of the triage panel will be shared with the following people within two days of the panel meeting:

- The referrer will be informed of the decision and rational. If the referrer disagrees with the decision, they can resubmit the notification form with additional evidence for the screening panel to consider.
- The Independent Scrutineer for oversight of decision making. (The Independent Scrutineer's views are advisory and do not replace partner responsibility)
- Executive leads for the statutory safeguarding partners for ratification of decision making.

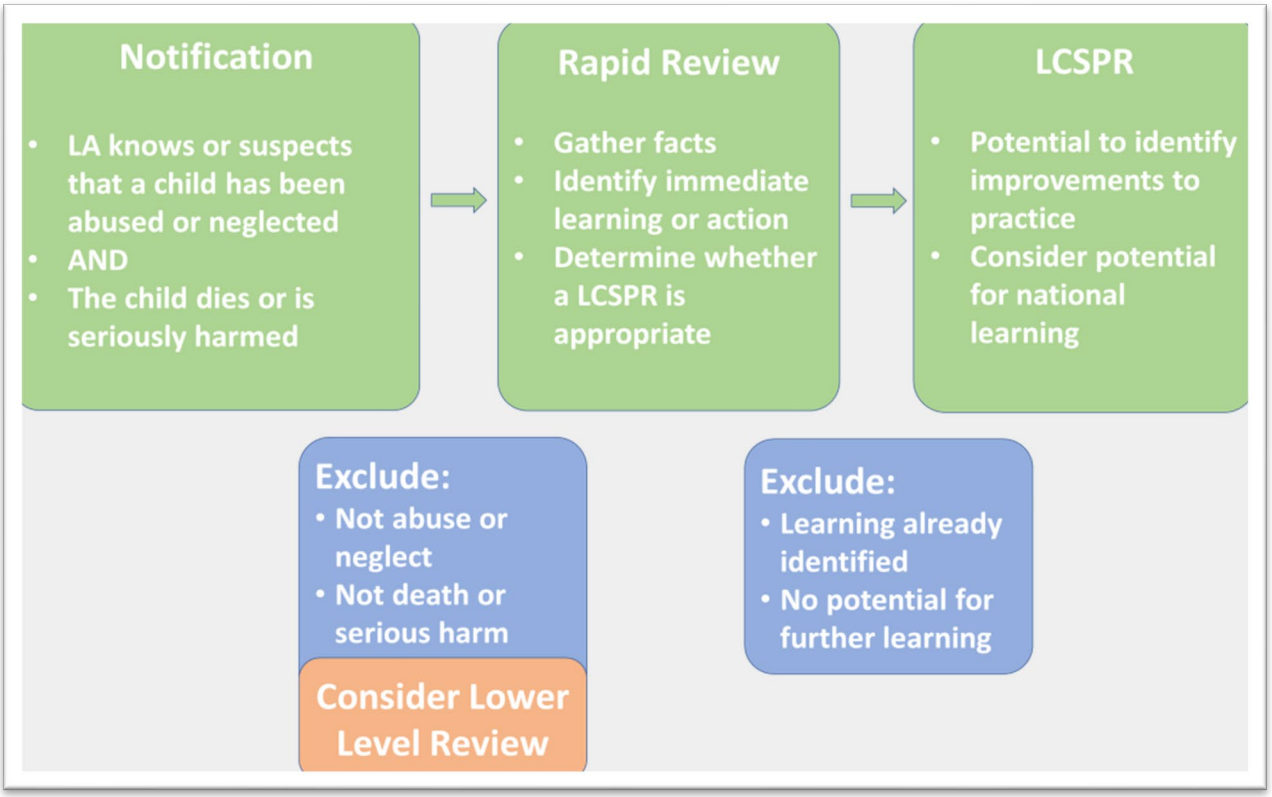
16.8 The record of the outcome of the Triage Panel will be added to the Case Review Log, and this document will be updated by the BCSP Business unit and reviewed at Operational and Business Group Partnership Meeting.

17. Lower-Level Review Process

17.1 The purpose of lower-level reviews is to identify improvements that can be made to safeguard and promote the welfare of children. As with Rapid Reviews & LCSPR's, Lower-Level Reviews are about understanding whether there are systemic issues, and whether and how policy and practice need to change, they should seek to prevent or reduce the risk of recurrence of similar incidents and also highlight/recognise areas of good practice which is transferable and can be promoted across the partnership. They are not conducted to hold individuals, organisations, or agencies to account.

17.2 All cases suitable for a lower-level review will be submitted to the Operational and Business Group for consideration and decision on the format (e.g. Learning Circle), scope, and timescales that the review will take.

17.3 Lower-Level reviews are not subject to publication requirements, however the learning will be disseminated across the partnership and referenced within the Safeguarding Partnership Yearly Report.



18. Rapid Review Process

18.1 Safeguarding partners are required to undertake a Rapid Review on all notified serious incidents. A Rapid Review is a multi-agency process that examines a Serious Incident Notification in order to:

> "Safeguarding partners should complete and submit their rapid review to the Panel within 15 working days of notification by the local authority. We recognise that this is challenging and a demanding timeframe. However, keeping in mind the nature and purpose of the rapid review, it is not unrealistic, and can help prevent drift and delays in learning and improvement."

	All agencies should inform the BCSP via the notification form within 24 hours of becoming aware of any serious incident which they think should be considered for a Rapid Review/ Child Safeguarding Practice Review.
Day 1	• Initial triage of serious incident notification by Triage Panel • Submit formal notification to the National Child Safeguarding Practice Review Panel within 5 working days of when the incident occurred
Day 2	• Notify all relevant agencies and requests review of agency records, completion of audit tool and chronology • Arrange Rapid Review meeting date
By Day 6	Individual agencies will review their records and submit their findings to the BCSP Business Unit

By Day 10	Rapid Review meeting to be held to gather the facts, consider immediate action and potential for practice improvements, and decide whether any further review is required, including whether a Local or National CSPR is indicated.
Between Day 11-13	Rapid Review Chair to write a Rapid Review report highlighting the key findings and recommendations, including next steps to be taken, and any lessons already identified.
Day 13-14	BCSP Designated Partners and Independent Scrutineer to review the Rapid Review report and provide rational to support decision making.
15 working days	Rapid Review Report to be submit to the National Panel outlining findings and decision, signed off by the Designated Safeguarding Partners.

18.2 The Rapid Review panel must contain:

- Representation from the three statutory partners who have delegated decision making responsibility.
- Those agencies who are universal to all families such as education, primary care, health visiting or/and school nursing services.
- Any other services that were working with the child and family for the scope of the review.
- Representatives from other local areas where they have relevant involvement with the child/family within the scope of the Rapid Review.

18.3 A single agency Information Gathering Form for a Serious Child Safeguarding Incident will be sent out to identified agencies within 2 working days of the triage panel deciding to hold a rapid review.

18.4 All agencies should secure all records/files in relation to the case through safeguarding leads/managers in their service area and a process agreed to ensure access is appropriate to those professionals involved in ongoing service delivery to the child/carers.

18.5 Agencies should return the completed template to the safeguarding unit business support officer within 5 working days.

18.6 The BSCP Business Team will merge all returns into a single collated document and a separate merged chronology which will be circulated to involved agencies 3 days prior to the Rapid Review meeting if time allows.

18.7 Participants must be of a sufficiently senior level within their organisation and be able to represent their agency at the rapid review meeting. They must have knowledge of the process and expectations and be able to reflect on practice and multi-agency effectiveness, take agreed actions back into their organisation for completion and provide assurance back to the Operational and Business Group that actions are completed, and that continual review, learning and audit is embedded in the learning process to improve practice.

18.8 There is an expectation that agency representatives will come to the rapid review meeting prepared, having a full understanding of the facts of the case, their own agency report and learning.

18.9 Participants will be expected to engage in the discussions relating to the key lines of enquiry, be able to contribute to a strengths-based review and analysis of single and multi-agency learning with a focus on improving practice within their own organisation, other organisations and as a partnership which in turn improves the outcomes for children and families.

18.10 The agency representative will be asked if they are in agreement or not with the decision to

progress to LCSPR. This will be an opportunity to provide views on the decision made but the ultimate decision will be made by the three statutory partners the Local Authority, Police and ICB.

19. Rapid Review Meeting

19.1 The process for the meeting is set out in the Rapid Review Meeting Agenda which reflects the National Panel's practice guidance, outlining what the Rapid Review Report should contain:

- Date of birth, gender and ethnicity of the child who has been harmed or who has died and whether the child had any known disability
- Which agencies have been involved in the rapid review, explaining any agency omission whose involvement would be usually expected.
- A concise summary of the facts, so far as they can be ascertained, about the serious incident and relevant context.
- Immediate safeguarding arrangements of any children involved.
- Family structure and relevant background information on the family – this will include all children not just the one(s) harmed or who died. Where available a genogram/family tree should also be included. Relevant information should be provided on the parents and any significant adults, including ages and any known physical or mental health problems or disability.
- Analysis of practice, including:
  - The quality of assessment of needs and risk, and information sharing and communication within and between agencies.
  - Analysis of the quality of individual and multi-agency decision making, highlighting what worked well and where improvements are indicated.
  - The quality of professional engagement with the family, including parents and carers.
  - How well sex, race, ethnicity, faith, sexual orientation, disability, social and economic background and other protected characteristics were explored in practice and what impact they had on children's and families' experiences.
  - The quality of support offered to children and their families, including support to address their cultural needs.
  - How any disability, physical or mental health issues, or environmental factors such as poverty or caring roles impacted on children's and families' experiences.
- Child's lived experience, including:
  - The child's voice including a summary of their identity and characteristics and how these impacted upon their experiences.
  - How children's vulnerabilities and risk of harm were recognised and responded to.
  - How well practitioners understood and responded to children's lived experiences, how well the voices and experiences of children were sought.
- Any immediate learning that has already been captured, and good practice and how this is being shared across the system.
- Reference to published national or local reviews or relevant research that can be used to support local learning.

- Single agency and Partnership actions to take forward including timescales.
- Decision and rationale as to whether the criteria for an LCSPR have been met and on what grounds, and if not, why not.
- Initial proposed Key Lines of Enquiry for LCSPR.

19.2 There may be additional headings that a chair considers necessary for a particular child and the circumstances for the review, but in all instances the above format should be completed.

19.3 The Rapid Review will determine whether or not a LCSPR should be commissioned using the criteria set out in Working Together to Safeguard Children 2026. The Rapid Review will therefore include a decision as to whether the criteria for a LCSPR have been met and on what grounds, and if not, why not. Clear reasons for the decision making should be recorded.

19.4 The timescale for completion of the Rapid Review is 15 working days from the date of the notification to National Panel. If this timescale is not met the Chair will need to set out why this is within the report and the National Panel are to be notified by the BCSP Business Unit.

19.5 The Rapid Review will decide on one of two options:

1. Does NOT MEET criteria for LCSPR
2. Does MEET criteria for LCSPR

19.6 If the decision is that the Rapid Review findings do not meet the criteria for a LCSPR, as all learning has been extracted; an action plan will be created and learning shared.

19.7 Meeting the statutory criteria for a LCSPR does not mean that safeguarding partners must automatically carry out a LCSPR. If the learning identified is already known about and changes in practice are in progress, then safeguarding partners may decide not to carry out a review.

19.8 If the Rapid Review panel believe that learning or actions are already in place, it is critical that the BCSP Statutory Partners are assured and test out that actions are in progress and the impact that these actions have generated.

19.9 If the decision is that it does meet criteria to commission a LCSPR, the key lines of enquiry and the questions that are to be answered by the LCSPR process should be set out in the conclusion to the Rapid Review. This may include recommendations for any national learning.

19.10 The Rapid Review report should include clear recommendations for the designated decision makers (of the statutory partners) pertaining to KLoE, proposed methodology, scope for commissioning the review and appropriate people to be part of the LCSPR panel.

19.11 Once completed, the Chair and BCSP Business Manager should quality assure the draft Rapid Review report before sharing with the following:

- BCSP DSP's Partners and Independent Scrutineer
- National Panel
- Referrer
- Contacts for any other ongoing reviews

19.12 Once completed the chair of the BSCP will sign off the Rapid Review report along with the three statutory partners prior to the submission to the National Panel via the SCP Business Unit.

19.13 Once received, the National Panel response should be shared with DSP's partners and the Chair of the panel with 1 day of receipt and any resulting action agreed

- If the National Panel and BCSP agree that the case meets the criteria for a LCSPR, a local or national CSPR will commence.
- If the National Panel and BCSP agree it does NOT meet the criteria for a LCSPR, no

further action will be taken as all learning, and actions are already in place.

- If the National Panel and BCSP are not in agreement with the outcome of a Rapid Review, discussion will be held about next steps

20. Local Child Safeguarding Practice Review (LSCPR)

20.1 Safeguarding partners are required to consider certain criteria and guidance when determining whether to carry out a LCSPR. They must consider whether the child's circumstances:

- Highlight or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.
- Highlight or may highlight recurrent themes in the safeguarding and promotion of the welfare of children.
- Highlight or may highlight concerns regarding two or more organisations or agencies working together effectiveness to safeguard and promote the welfare of children. Is one which the National Panel have considered and concluded that a local review may be more appropriate.

20.2 They should 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, Police area or ICB 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.

20.3 The National Panel does not have the power to require a Safeguarding Partnership to undertake a review. The decision to proceed to a LCSPR is a local decision for which the local Safeguarding Partners are accountable. This includes the identification of cases, commissioning and supervising of reviews and the publication of reports and embedding learning.

21. Commissioning of a Reviewer (s) /Independent Author

21.1 The DSPs are ultimately responsible for commissioning and supervising reviewers for local reviews.

21.2 Safeguarding partners may consider using their own capacity to undertake LCSPRs, as appropriate, and provided the person has suitable skills in applying a systems approach to undertake reviews as outlined in Working Together 2026. Alternatively, the safeguarding partners also have the option to commission an Independent Reviewer / Independent Author

21.3 In all cases the safeguarding partners will consider whether the reviewer has:

- professional knowledge, understanding and practice relevant to local child safeguarding practice reviews, including the ability to engage with practitioners, children, and families
- knowledge and understanding of research relevant to children's safeguarding issues
- ability to recognise the complex circumstances in which practitioners work together to safeguard children
- the ability to understand practice from the viewpoint of the individuals, organisations or agencies involved at the time rather than using hindsight

- the ability to communicate findings effectively
- any real or perceived conflict of interest

21.4 The Reviewer(s) / Independent Author will work with the Child Review Panel which will be established once the review is commissioned and will provide oversight and quality assurance of the process

21.5 A written contract will be agreed with the Reviewer(s) / Independent Author for the LCSPR and prepared by the BSCP Business Unit. This will include insurance details (including public liability), payment arrangements, and clear timescales for report progress and completion.

21.6 The Reviewer / Independent Author will develop the initial terms of reference for the LCSPR. At the initial panel meeting the Case Review Panel will agree with the reviewer/ independent author the method by which the review should be conducted.

21.7 The scope and terms of reference will stem from the learning identified in the rapid review. Key lines of enquiry should be few in number and focused on the most important issues for learning.

21.8 This should be accompanied by a concise summary of the circumstances and background of the case to lend appropriate context to the reflection and learning of the LCSPR that will follow.

21.9 While undertaking an LCSPR, alternative lines of enquiry or methods might be required, and any amendments will be reflected in the final report.

22. Case Review Panel (CRP)

22.1 Once the decision has been made that a LCSPR will be undertaken, a Case Review Panel (CRP) will usually be established, and panel members will have had no immediate line management of the case under review.

22.2 The CRP will include representatives of the three statutory agencies (Local Authority; Police; ICB), along with representatives from agencies who had significant involvement with the child and any relevant subject matter experts

22.3 A CRP chair who has the necessary expertise in chairing/leading will be selected from case review panel members. The chair will support the Reviewer/ Independent Author to analyse and evaluate information provided by agencies including responding to the key lines of enquiries already set, or any new ones emerging.

22.4 The CRP Chair will be responsible for effectively leading and coordinating the CRP and for quality assurance of the final report. Where single agency information is not of the quality expected then the Chair will ask the BCSP Business Unit to contact the relevant agency and ask for the information to be revised and resubmitted in a timely manner.

22.5 The CRP Chair will set the panel meeting schedule and timings appropriate to the conduct of the review and its methodology, and these will be held face to face where practicable. Whilst the frequency and number of meetings may vary, the CRP will in most instances progress through the following three stage process, in order to establish; monitor and finalise the review.

23. Case Review Panel Process

23.1 CRP Stage 1 – Establish

The Case Review Panel will have responsibilities from the outset to:

- Endorse the Terms of Reference including the agreed key lines of enquiry, and the

methodology to be used, utilising the best practice guidance and templates provide

- Consider how best the child and family can be involved in the review and identify trusted contacts who can support family involvement in the process, including consideration of an advocate.
- Identify, inform, and establish links to any other processes ongoing or planned with other interested parties such as the Senior Investigating Officer, Crown Prosecution Service or Coroner.
- Agree the nature and extent of expert or legal advice required.
- Determine what information is required to conduct the review and identify any additional reports or information required.
- Brief the legal and media teams to develop media and communications plans, and gain support and appropriate advice, publishing considerations especially with complex and reputational LSCPR's
- Set activities to achieve timescales including future panel meeting dates and times.

23.2 Methodology:

A LCSPR should not necessarily be limited to reviewing the specifics of one child and a specific incident and instead can be used to also explore broader aspects of practice, to ascertain whether there are systemic practice issues to be addressed i.e. underlying issues that are influencing practice more generally.

To achieve this, a LCSPR can benefit from bringing in wider relevant evidence related to the case. For example: the context of the local area, data and analysis relating to agencies and services, national or international evidence and learning from other local statutory reviews and/or national reviews.

If the LCSPR is being used to tackle perennial problems that need further or perhaps different attention, it may begin with a focus on the child referred alongside a summary of related learning from similar reviews with consideration given as to whether this case generates any new insights, or whether the focus of the statutory learning review will assist in understanding the extent to which change has been achieved and what barriers and enablers to practice development still exist.

In summary, the methodology chosen should promote:

- An exploration of the barriers and enablers to good practice, reviewing the underlying causes of systemic issues and risks, leading to effective learning.
- The engagement of the child/family/those with lived experience.
- Improvement action to prevent future deaths or serious harm/abuse/neglect occurring
- Opportunity to explore examples of good practice, research evidence, other relevant reviews, policy, and statute to identify lessons to apply to future practice.

23.3 Timescales:

At the commencement of the LCSPR the Case Review Panel Chair will establish an agreed timetable of review meetings in accordance with the required timescales of the review and set specific parameters, including timescales for the completion of chronologies, conversations and any other learning event which includes further exploration of practitioners' views.
Working Together to Safeguard Children 2026 states that depending on the nature and complexity of the case, the LCSPR review report should be completed and published as soon as possible and no later than six months from the date of the decision to initiate a review. Completion of reviews outside of that timeframe required clear rationale provided to Case Review panel for agreement of revised timescale.

23.4 CRP Stage 2 –Review and Learning Stage:

During this phase the following functions are likely to be required of the Case Review Panel in line with, and proportionate to the methodology used and circumstances:

- Maintain links with interested parties and parallel investigations.
- Make arrangements to secure the contribution of front-line staff to the review.
- Secure the contribution of the child and their family and others as appropriate.
- Receive and scrutinise information and draft reports.
- Conduct/commission any further enquiries.
- Identify practice and systemic issues.
- Agree a framework for the report and consider draft versions, including SMART recommendations.
- Allow time for the parents/carer, family or others to read the report and reflect on the findings before it is signed off.
- Where appropriate - identify a pseudonym for use in the final report.

23.5 Parallel investigations:

The BSCP Review Panel Chair will maintain contact with the BCSP Partnership Manager of all parallel review or investigation processes and to ensure that any coordination and joint commissioning arrangements are effective.

Where there is an on-going criminal investigation, the Case Review Panel Chair will receive regular updates from the Police representative to ensure appropriate processes are being followed. This relates particularly to any planned interviews with family members, practitioners and managers and must take into account that any one of these people may be a potential witness or even defendants in a future criminal trial.

Coroners are responsible for investigating violent, unnatural deaths or deaths of unknown cause and deaths in custody, or otherwise in state detention, which are reported to them. Any LSCPR that falls within this remit the partnership with liaise with the coroner as and when it is appropriate. Any correspondence with the coroner must go through Barnsley Council Legal Department.

23.6 CRP Stage 3 – Finalise

As part of this stage, the Case Review Panel will ensure contributing agencies have had the opportunity to confirm the accuracy of facts and interpretation of their involvement in the report and this will be endorsed through the minutes of the panel.

During this stage, the members of the Case Review Panel will discuss and agree the key learning themes arising from the review and determine what actions should be taken to address the practice or system learning; and finalise the report.

To support the Case Review Panel to effectively quality assure, the below framework questions will be utilised to consider whether an LCSPR is of good quality:

- Is there a clear rationale for the scope of the LCSPR based on the analysis from the rapid review? Is the review focused? What are the key lines of enquiry that the review is seeking to address?
- Has the chosen methodology helped with exploring the identified themes?
- Where relevant to the focus of the review, does it give a sense of the daily life of the child/children?
- Where relevant to the focus of the review, does the report consider the race/ethnicity

and any disability of the child/children? Does it interrogate potential direct or indirect experiences of discrimination?

- Where relevant to the focus of the review, does the report explore intersectional identities of the child/children?
- Where relevant to the focus of the review, does the report show an understanding of the distinct context for the child/children (background, culture and history)?
- What is the quality of analysis and interpretation of findings? Does the review go beyond simply identifying 'what went wrong' to consider the impact of organisational context and leadership, and any system issues underlying practice?
- What is the quality of identified learning points, recommendations, and any linked action plans?
- Is the report timely and with a quality structure (including independence of author, accessibility, usefulness, length etc)?
- Are there implications for local/national practice and/or policy?

It is important, where possible, to identify whether any of the issues identified in an LCSPR resonate more widely and therefore should be disseminated across the system to support effective local practice. The final report should detail issues that highlight the conditions in which practice takes place alongside any identifiable practice improvement themes.

Any recommendations should be few in number and focused on improving practice, rather than simply increasing bureaucracy with more procedures and rules, monitoring and control. Reviews should avoid making recommendations that are vague and general, repeating what should be standard practice, or that seek assurance around issues that should have been covered in the review itself.

It is the responsibility of the Case Review Panel to work with the Chair and Independent Author to develop an action plan which takes account of the wider learning improvement cycle. A draft action plan should be included as part of the final report and should include:

- Single & Multi-Agency SMART actions to address the recommendations
- A timeline for publication of the report and where possible a date identified.
- Actions detailing who should see the report, when and how. This should include what support will be provided for family at the time of meeting and after seeing the report.
- The process of reading the report needs to meet the needs of families, allowing time in advance of publication to ensure they are aware of the findings and recommendations.

All the records collected as part of the review will be held securely and confidentially for an appropriate period in line with the SCSP Data Sharing Agreement and GDPR regulations.

24. Publication and dissemination of learning

24.1 On completion, the final report and action plan will be signed off by the Case Review panel chair prior to presenting to the Deputy Safeguarding Partners and relevant stakeholders including the independent scrutineer. They will:

- Consider and respond to the key findings.
- Consider any actions requiring immediate change to safeguard children at risk of abuse and neglect highlighted by the review.
- Agree how the learning themes will be taken forward including who is responsible for their implementation and how this will be monitored.

- Be assured that arrangements are in place to monitor and evaluate the impact of actions taken to address the learning themes.
- Ensure that any reports to be published are fully anonymised.
- Agree arrangements for publication or confirm to whom the review or parts of the review are to be made available.
- Commission the dissemination of the key findings to interested parties including feedback and debriefing to staff, family members and media.
- Publish a summary of the learning from statutory reviews in its annual report alongside an account of the actions taken and the impact of those actions on improving the safeguarding system/practice.

24.2 The Safeguarding Partners are required to publish the reports from a LCSPR unless they consider it inappropriate to do so. Regardless of publication in full, they must publish any information about improvements that could be made following the review.

24.3 Consideration should be given as to how best to manage the impact of publication on children, family members, practitioners and others closely affected by the case. The wishes of the child's family should be considered as part of the publication and media planning. The proposed publication arrangements should be discussed with the family and appropriate steps should be taken to minimise the distress that any media attention surrounding publication may cause to family and friends.

24.4 Since the Local Authority is the lead agency, media and communication issues will usually be co-ordinated by the council's communications team. This will be done in collaboration with the communications teams of the other agencies involved, alongside agreed representatives of the partnership.

24.5 The arrangements for informing practitioners should also be considered. Senior managers from each agency should take responsibility for informing frontline staff of the date of publication and ensuring they have appropriate support.

24.6 The safeguarding partners must send a copy of the full report to the National Panel, Ofsted and to the Secretary of State no later than seven working days before the date of publication.

24.7 Published reports should always include the name of the reviewer and be available to download on the LSCP website. Reports should be publicly available for at least one year and archived reports will be available on the request from Safeguarding Partners.

25. Embedding learning:

25.1 The purpose of the LCSPR is to identify improvements that can be made to safeguard and promote the welfare of children. Disseminating and embedding learning is therefore crucial to the process and will consist of four approaches to ensure a proportionate approach to maximise opportunities for learning:

1. **LCSPR Report published on BCSP website and NSPCC repository**
2. **Briefing Guide or Executive Summary –** Short communication briefings for wide dissemination.
3. **Power point presentation/ video –** For use in team meetings and learning events
4. **Resource Pack which highlights the reviews' key themes –** To be used in BCSP training and workforce development events

26. Case Review Monitoring

26.1 The Operation and Business Group will be responsible for overseeing all case review learning and will meet on a quarterly basis.

26.2 Once a case review has been signed off as complete and an action plan is in place, the review information will be added to the action plan log so that monitoring of the action plan can commence.

26.3 The Operational and Business Group will be responsible for ensuring there are effective links with the relevant partnership subgroups so that workforce development and learning are undertaken and its impact measured.

26.4 Quarterly highlight reports from Operation and Business Group chair to the Executive Group will include data about the number and timeliness of reviews and progress against action plans and learning. Other intelligence about the conduct of reviews and learning from the reviews themselves will be utilised to continuously improve the effectiveness of reviews.

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