BARNSLEY SAFEGUARDING
CHILDREN PARTNERSHIP

Barnsley Child Safeguarding

Practice Review

Toolkit

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Overview of Different Types of Learning Reviews

Effective local liaison is required between Multi-Agency Child Safeguarding Arrangements, Adult Safeguarding Boards, Community Safety Partnerships and Multi-Agency Public Protection Arrangements to determine the most appropriate review process to maximise learning and minimise duplication of effort and reduce anxiety for families involved.

Summarised below is a brief outline of the main types of statutory reviews:

Domestic Abuse Related Death Reviews

Domestic Abuse Related Death Reviews (DARDR) are commissioned by Community Safety Partnerships and overseen by the Home Office. A DARDR is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.

Safeguarding Adult Review

The purpose of a Safeguarding Adult Review (SAR) is to identify lessons to be learned from the case and for the lessons to be applied to safeguard adults more effectively in the future. Where a serious case may meet the criteria for a SAR or Local Child Safeguarding Practice Review, liaison will take place between the Adult and Children safeguarding arrangements to discuss primacy and agree the way forward. The majority of these cases are likely to focus on transition to adulthood and the potential to improve inter-agency working.

Multi-Agency Public Protection Arrangements – Serious Case Review

The purpose of the Multi-Agency Public Protection Arrangements (MAPPA) is to oversee the management of violent and sexual offenders. MAPPA SCRs examine the effectiveness of partnership working in managing the risk and preventing further offending in the community. The aims of the MAPPA SCR will be to establish whether there are lessons to be learned, to identify them clearly, to decide how they will be acted upon, and, as a result, to inform the future development of MAPPA policies and procedures in order to protect the public better. It may also identify areas of good practice.

Child Death Review Arrangements

A child death review must be carried out whenever a child dies, regardless of the cause of death. It is the responsibility of the local authority and clinical commissioning group (the ‘child death review partners’) to ensure the review takes place and to make arrangements for the analysis of information from all deaths reviewed. The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If child death review partners find action should be taken by a person or organisation, they are required to inform them.

Sample Confidentiality Agreement for Rapid Review / Local Child Safeguarding Practice Reviews

In your role as a member of, or attendee at, one of the [insert Partnership name]'s Rapid Review or Local Child Safeguarding Practice Review meetings, you will have access to a variety of personal and business information which may be held in electronic format or in hard copy, or may be spoken in face-to-face or in telephone conversations. Much of this information is likely to be confidential in nature.

Confidential information may include:

- Personal information about identifiable persons, living or dead;
- Commercially sensitive information;
- Information about actions which have been proposed to the Partnership or Sub-Group, on which a decision has not yet been reached; and
- Information about the actions of an agency or agencies in the city.

Much of the business of the [insert name of Partnership] is of a sensitive nature and members and observers must guard against wrongful disclosure in the interests of children, young people and families and the reputation of the Partnership.

All information received in connection with the business of the Safeguarding Children Partnership is to be regarded as confidential, unless:

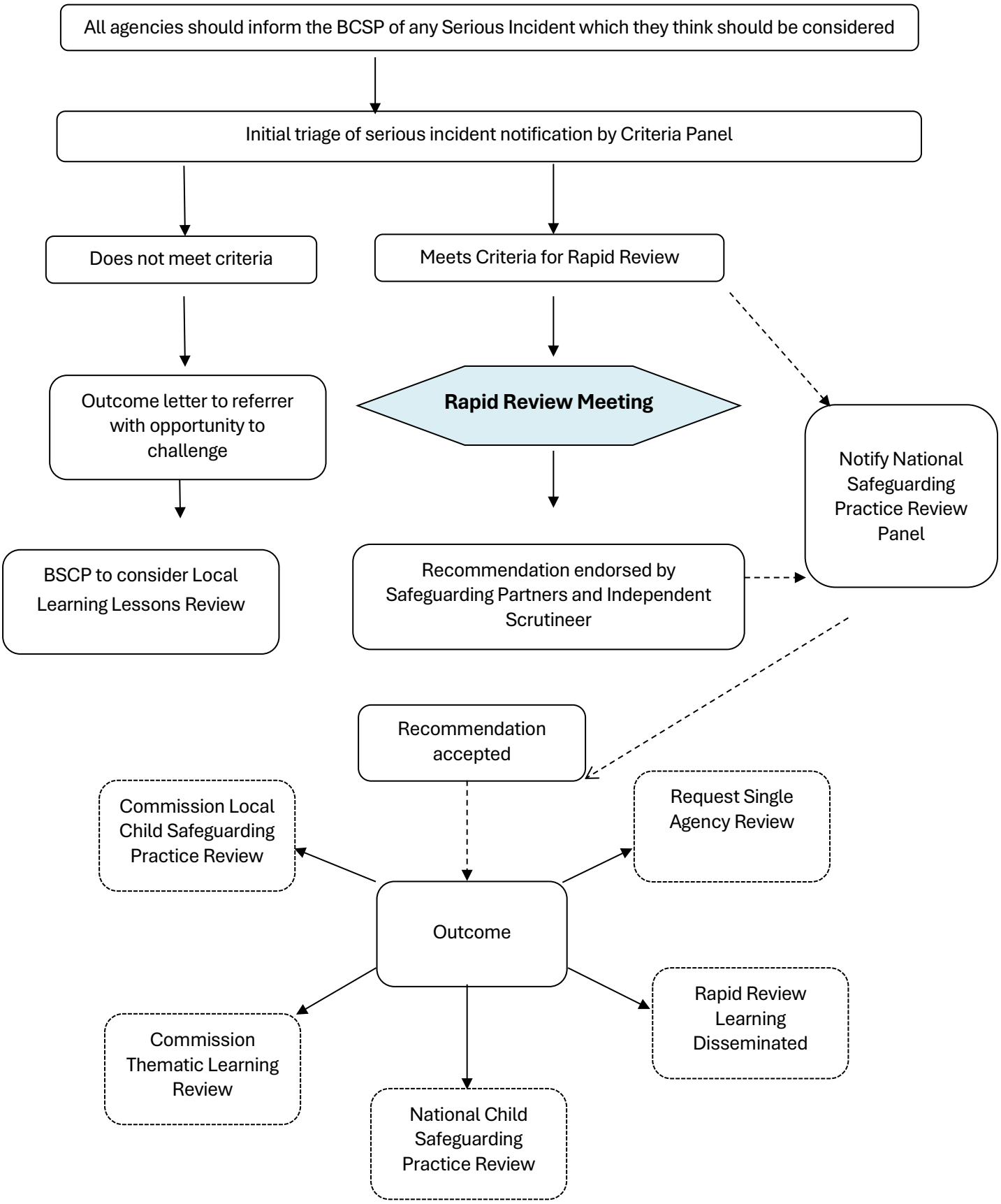
- It has been given to you with a clear instruction to discuss it with specified persons;
- It has been given to you as part of a consultation exercise, with a clear expectation that you will circulate it;
- It is an accepted decision that has been, or is to be, publicly announced; or
- It is already in the public domain (provided that this has not happened because of a breach of this agreement or of another duty of confidentiality).

With the above exceptions, any information disclosed to you in the course of your duties must not be copied or disclosed to any third party without the prior agreement.

I have read the above statement and agree that I will respect the confidentiality of information disclosed to me.

NAME	AGENCY AND FULL CONTACT DETAILS (Postal address, telephone number and email)	SIGNATURE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Child Safeguarding Practice Review Process Flow Chart



Referral Form for a LCSPR/Case Review

This form should be completed when notifying Barnsley Safeguarding Children's Partnership (BSCP) that a safeguarding children's review may be required.

This form should be completed to notify the BSCP of:

- Request a Rapid Review / Local Child Safeguarding Practice Review
- Request a Lower-Level Review / Good Practice Review

Criteria for a Local Child Safeguarding Practice Review

Child Safeguarding Practice Reviews are those in which:

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

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

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.

Referrers should discuss the case with their agency designated safeguarding lead/officer to help formulate the rationale and refer to the Child Safeguarding Practice Review Panel: Guidance for Safeguarding Partners June 2025

THIS REFERRAL SHOULD FOLLOW A DISCUSSION WITH A NOMINATED MANAGER OR SAFEGUARDING ADVISOR IN YOUR AGENCY.

Type of review being requested or notification being made Please highlight which of the criteria below has been met (Please check all that apply with an X)	
Low- Level Review *This should be selected for cases where the criteria for LCSPR is not met but learning could be achieved via Learning Circle / Multi-Agency Review or similar process. This should also be selected for cases of Good Practice that you wish to have reviewed*	
Rapid Review / LCSPR / SI Notification *This should be selected for cases where the referrer believes the criteria for a Rapid Review/ LCSPR/ Serious Incident Notification is met REFERRAL SHOULD BE MADE WITHIN 24 HOURS* Please refer to the criteria in the Child Safeguarding Practice Review Guidance	
Death of Care Leaver (Up to & including 24yrs of age) *This should be selected for cases where a care leaver has died, there is no necessity for abuse or neglect to be a factor for this notification. If neglect or abuse is a factor also consider selecting the Rapid Review/LCSPR box above to allow further consideration of the case.*	

Child Death Notification This should be selected for a child who has died within Barnsley or when a child dies who normally resides in Barnsley where you believe meet the child meets the criteria of a LSCPR *REFERRAL SHOULD BE MADE WITHIN 24 HOURS OR AS SOON AS CONCERNS ARISE*	

1 Notification Details

Date of Referral:	
Date of Incident:	
Name of Person making request and contact details (telephone number and e-mail address)	
Designation of person making request:	
Senior line manager authorising notification/referral:	
Contact details of senior line manager authorising notification/referral:	
Is this referral for a Good Practice Review? (Yes / No)	
Number of Children involved *Please note if more than one child please ensure you provide the following details for all the children.*	

2 Reason for the Review

Please outline the Incident / why you are making this referral/How it meets the threshold for a Rapid Review/LSCPR (if appropriate): what has happened ….

Please outline any immediate or proposed action taken in response to incident / referral. Include any key actions identified from your review of your agency's involvement in the case

Please provide a brief outline of the child and family circumstances **To help, make an assessment of factors that may have influenced the case** Consider information relating to: • History • Developmental Issues – including behaviour, education and health • Parental Capacity – including provision of care, substance misuse, mental health, domestic abuse and attachment issues • Family & Environment – including housing, wider family support, employment & income and diversity • Multi-Agency working – including how agencies worked together and any barriers to this

Please add any additional information you think may be relevant and may assist decision-making:
Please identify below any potential issues for further exploration at Rapid Review: **Examples:** • **Risk Indicators** • **Issues for process and practice Issues for multi-agency working**
Views of the Child, Young Person and / or their Family **Please provide any information that your agency holds in relation to the child's views, wishes or feelings of their circumstances prior to the incident?**

3 Family Composition Details

Name of Child/ren	
Date of Birth	
Home address	
Gender (Gender Preference)	

Ethnic Origin	
Faith/Religion	
Disability	
Details of Parent / Carer / Guardian	
Education or early years provision attending	
Name and address of educational establishment	
Is the child known to other agencies (if yes please complete below section)	
Date of Death or Serious Incident (please specific which) ***Note: for lower-level review requests where there has been no death or serious incident, please input date of incident that led to this referral. For Good Practice Reviews please detail N/A***	
Address of location of incident ***For Good Practice Reviews please detail "N/A"***	
Is this case known to be the subject of Police / criminal investigation? (If so, who is the lead investigator?) ***For Good Practice Reviews please detail "N/A"***	
Is this case known to be the subject of a Coroner's Inquiry? (If so, who is the key contact?) ***For Good Practice Reviews please detail "N/A"***	
Are there any adult safeguarding concerns and have these been shared via completing an adult referral form? (If so, who is the key contact?) ***For Good Practice Reviews please detail "N/A"***	

Details of Family Members and any Significant Others

Name and Address	Relationship to Child	Date of Birth	Legal Status	Ethnic Origin

What action has been undertaken to safeguard and protect the child/and or any siblings of the child who is the subject of this referral?

Other agencies known to be involved

Agency	Contact Details: Address, Telephone and E-mail	Reason for involvement (include whether current or not)

NOTE: THE ABOVE SHOULD FOLLOW A DISCUSSION WITH A NOMINATED MANAGER OR SAFEGUARDING ADVISOR IN YOUR AGENCY

ANY REFERRALS TO BE CONSIDERED FOR A RAPID REVIEW NOTIFICATION TO BE MADE WITHIN 24 HOURS.

Advice and Submission:

For any advice on how to complete the referral and for all completed referral forms these to be sent **by secure email to** BarnsleySafeguardingChildrensPartnership@barnsley.gov.uk

For SCP use only

Triage Decision

TO BE COMPLETED BY THE BSCP Screening Panel			
Names and organisation of Panel Members making decision:			
BMBC:	SYP:	ICB:	Other:
Referral Decision of Screening Panel (tick √ one)			
Meets threshold for Rapid Review	Does not meet threshold for Rapid Review or review	Meets threshold multi agency review but not a Rapid Review	Queries back to referrer before decision can be made
Rationale for the Decision			
Date Agreed			
Oversight and Comments by Designated Safeguarding Leads			

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BARNSLEY SAFEGUARDING CHILDREN PARTNERSHIP

Information Gathering Form for a Serious Child Safeguarding Incident

This information is being requested by Barnsley's Safeguarding Children partnership (BSCP)

This information gathering form is to be completed by all agencies who are working with the child, parents/ carers or family subject to a serious child safeguarding incident notification. The information in this form will assist the BSCP in considering whether the case meets the criteria for a Local Child Safeguarding Practice Review.

Please complete Section A and Section C. If you are aware of any missing information or possible discrepancies in information within Section B please amend these, highlighting any amendments made.

Section A: Agency / Organisation details

Details of Person completing this form	
Name:	Organisation:
Contact details Email: Tel Number:	Date form completed:

Section B: Serious Child Safeguarding Incident information and Family Composition

Name of Child	
Date of Birth	
Ethnicity	
Home address	
School / early years provision / other	

Other Relevant Family Details (including extended family):

Relationship to Child	Name	Date of Birth	Ethnicity	Address if different to above	School / Early years provision / other if applicable

BARNSLEY SAFEGUARDING CHILDREN PARTNERSHIP

Short summary of Serious Child Safeguarding Incident (including date of incident):

Section C: Agency information and involvement (to be completed by the agency submitting this form)

1. Is the child, or family known to your organisation (current or previously)? Give dates of involvement
2. Provide a brief summary of your agency / service's involvement with the subject child AND the individuals listed in the family composition. Please provide information in relation to the timeframe from (Date), whilst including any additional information outside of that timeframe you feel relevant.
3. Are there any adult safeguarding concerns? If so have these been shared with Adult Social Care (please provide details of key contact / copy of referral)
4. Please identify any impact COVID and associated lockdowns may have had on your agency's work with this family including changes in service provision and engagement with the family.
5. Please outline areas of good practice and areas of learning for your agency including any actions (please include timescales, outcomes and lead person/role).
6. Please include any further relevant information that you wish to inform the Rapid Review process.

Other Agencies you know to be involved:

Agency	Contact Details: Address, Telephone and E-mail	Reason for involvement (include whether current or not)

BARNSLEY SAFEGUARDING CHILDREN PARTNERSHIP

Please return completed form to: barnsleychildrenssafeguarding@barnsley.gov.uk partnership by COP (Date).

INSERT RELEVANT LETTERHEAD

Date: [insert date]

Dear Safeguarding Leads,

Child Safeguarding Practice Review – Initial Scoping and Information Sharing

We have received notification of a serious incident which may meet the criteria for a Child Safeguarding Practice Review. We will, therefore, be holding a Rapid Review to consider the case.

To inform the Rapid Review meeting, we need to gather the basic facts about the case and determine the extent of agency involvement with the child and/or any family members. This will help the Safeguarding Partners decide whether to undertake a formal Child Safeguarding Practice Review and to determine the most appropriate method to identify and cascade learning from this case.

We are initially asking agencies to:

1. Clarify whether your organisation had any involvement with the subject child and/or named individuals within the family composition outlined in Section 1 of the attached form.
2. Complete the attached *Initial Scoping and Information Sharing* form if you have had any involvement with the subject child or a member of their family.
3. Secure all records/files in relation to this case, ensuring that they are removed to a secure place where they are not accessible to agency personnel other than through you or your nominated representatives.
4. Keep your agency's submission in relation to this case separate from the case records/files.

If the child or family is not known to your organisation, please confirm this in writing.

We are required to hold the Rapid Review meeting and agree the way forward within timescales outlined in national guidance (currently within 15 working days). This *Initial Scoping and Information Sharing Form* should, therefore, be returned to us at the address included on the form **within 5 working days**. In this case this will be **[insert submission date].**

If you require any further information, please contact [insert contact name and phone number].

Yours sincerely,

Add appropriate signature for area

Enc: Template-Information Gathering Form for a Serious Child Safeguarding Incident

AGENDA

RAPID REVIEW – (Insert Child's Initials)

Date:

Time:

Venue:

	Agenda Items	Lead	Time
Rapid Review Chair:			
Business Support:			
1.	Welcome/introductions/apologies		
2.	Overview of incident		
3.	Confirmation of family details		
4.	Agency reports		
5.	Confirmation of immediate safeguarding actions/evidence of historic or current domestic abuse		
6.	Decision Summary and Rapid Review Panel recommendation for National Panel		
7.	AOB		

BARNSLEY SAFEGUARDING CHILDREN PARTNERSHIP REPORT	
Meeting:	Rapid Review
Date of meeting:	
Author:	
Status of Report	Confidential

Child Details:

Name of Child / subject of review	
Date of Birth	
Ethnicity	
Home address	
School / early years provision / other	

Other Relevant Family Details:

Relationship to Child	Name	Date of Birth	Ethnicity	Address if different to above	School / Early years provision / other if applicable	Disability

In line with Working Together 2026, 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 and promote the welfare of children
- decide what steps to take next, including whether or not to undertake a child safeguarding practice review

Summary of Incident:

Immediate actions taken to Safeguard Children:

Intervention Summary of Agency involvement:

X organisations attended the meeting who had direct involvement with the family and were able to share information from their agency.

Present at the Rapid Review		

Information shared by each agency:

Analysis of rapid review information and key learning for both single and multi-agency working:

Single Agency Actions:

Multi Agency Actions:

Decision of safeguarding partners regarding forward approach and rationale

The criteria safeguarding partners must take into account include whether the case:	
highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified	
highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children	
highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children	
is one the panel has considered and has concluded a local review may be more appropriate	
they have cause for concern about the actions of a single agency	
there has been no agency involvement, and this gives them cause for concern	

It was the decision of the meeting that

Date:

Signatures by agreement of DSP

Insert onto the relevant letterhead

Date: [insert date]

Dear [Insert name of current Panel Chair],

Decision of the Rapid Review of [insert case name / reference]

I am writing to you in your capacity as Chair of the Child Safeguarding Practice Review Panel. Our Safeguarding Partners received notification of a serious incident which may meet the criteria for a child safeguarding practice review on [insert date] and have, therefore, undertaken a Rapid Review to consider the case.

This Rapid Review included a representative from each of the Safeguarding Partners and concluded that the case meets the criteria for a national Child Safeguarding Practice Review / meets the criteria for a local Child Safeguarding Practice Review / does not meet the criteria for a Child Safeguarding Practice Review. [Delete as appropriate and then turn the related text black and delete this instruction.]

I attach for your information a copy of our completed Rapid Review which provides a summary of the case and the decision and rationale of the Safeguarding Partners. [The decision has been endorsed by INSERT NAMES of the partnership's Delegated Safeguarding Partners/Independent Scrutineer].

I trust this is sufficient information for you to share with the Panel. However, please do not hesitate to contact me [or insert contact details of any relevant individual] if you require any further information.

Yours sincerely,

Add appropriate signature for area.

Enc: Rapid Review Template

Insert relevant area logo(s) and address here

Local Child Safeguarding Practice Review Terms of Reference

CHILD REFERENCE:	
DATE:	

1.	INTRODUCTION
	The aim of this review is to identify improvements that can be made to better safeguard children and to prevent, or reduce the risk, of recurrence of similar incidents. The review will undertake a rigorous and objective analysis of what happened and why. It will consider whether there are systematic issues, and whether and how policy and practice need to change. It should be noted that the review is not being conducted to hold individuals, organisations or agencies to account as there are separate processes for this.
2.	CASE SUMMARY
	Summary of Serious Incident: **Information about the Family:**
3.	REVIEW TEAM
	Name of Lead Reviewer: **Membership of the Review Team:** *The names of the Review Team members and the organisation they represent should be included here along with details of any specific responsibilities of these members (such as the Police representative liaising with the Senior Investigating Officer and Crown Prosecution Services where there are parallel investigations).*

4.	SCOPE OF THE REVIEW
	Time Period to be Considered by the Review and Rationale: **Key Issues to be Addressed by the Review:** (NOTE: These may evolve as more information becomes available during the review. In line with the Regional Guidance, these will need to consider the 'why' questions.)
5.	PLANS TO INVOLVE CHILDREN AND FAMILY MEMBERS
	NOTE: Plans to engage children and family members will need to take into account the legal considerations outlined in Section 4 below. This section should describe the agreed plans to involve children and family members and who will be responsible for making contact / following up.
6.	METHODOLOGY
	NOTE: The headings below are based on the tools described in the Regional Toolkit and Practice Guidance. Each case will be examined individually and an appropriate methodology agreed. The headings should, therefore, be altered or deleted depending on the methodology used. **Chronologies:** **Learning Template / Information Report:** **Reflective Learning Workshop / Feedback Session:**
7.	LEGAL CONSIDERATIONS

	Parallel Investigations: **Legal Advice:**
8	OTHER CONSIDERATIONS
	NOTE: The other factors that will need to be considered will vary from case to case. However, as a minimum, it will be important to identify whether there are any racial, cultural, linguistic issues that need to be considered or issues related to the religious background of the child or members of their family.
9.	TIMELINE AND KEY DATES
	This section should include key milestone dates agreed for the review, including the target date for the presentation of the learning to the Safeguarding Partners.

NEEDS TO BE DRAFTED TO INSERT INTO BMBC LETTERHEAD

Dear [insert name],

Firstly, I would like to say how sorry I am about the tragic death / serious injury of your daughter / son / brother / sister / granddaughter / grandson, [insert child's name]. I understand this must be a very difficult time for you and your family.

I would like to introduce myself and explain why I am writing to you. My name is [insert name] and I have been asked to lead an independent review to look at the way in which agencies and services worked with your family in the time before [insert name] died / suffered [insert serious injury].

The review is officially called a 'local Child Safeguarding Practice Review'. The purpose is to consider how organisations (such as police, health, schools and the local council) worked together and whether there are improvements that could be made to prevent, or reduce the risk, of similar incidents happening in the future. I enclose a leaflet which explains more about these reviews.

This review is completely separate to any investigation into how [name] was [seriously injured / sadly died] that may be taking place. When I am able, I would like to visit you to hear about the services you received. We believe it is very important that family members share their experience, including the quality of services and whether anything could have been done better.

If you are willing to help us learn from this sad case, please contact [insert name] on [insert telephone number] so that a meeting can be arranged. If you have any questions or concerns, please contact [insert name] on [insert telephone number].

Yours sincerely,

[Insert name], Independent Lead Reviewer

The Independent Lead Reviewer for your case is:

If you have any questions or want to know more contact:

Insert here contact details of the person who will be able to answer questions and queries

Insert relevant logo(s) here

Child Safeguarding Practice Reviews

Information for Parents and Carers

What is a Child Safeguarding Practice Review?

The Police, Health, Council and other agencies are required to work together to keep children safe. When things go wrong (such as when a child or young person has been seriously harmed or has died as a result of possible abuse or neglect) they are required to take action to prevent similar death or injuries happening in the future.

To do this they usually undertake a Child Safeguarding Practice Review. This examines how organisations worked together to provide services to the child or young person who is the focus of the review, and to their family.

The purpose of the review is to:

⇒ establish whether there are any lessons that can be learned by professionals and organisations;

⇒ identify who those lessons are for; and

⇒ plan how the lessons will be acted upon.

A Safeguarding Practice Review is not an investigation into how a child died or was seriously harmed. It is also completely separate from any investigation by the Police or the Coroner.

Whilst we recognise your grief and anxiety, we believe that the circumstances relating to your child mean that a Child Safeguarding Practice Review should be carried out.

Who will carry out the Safeguarding Practice Review?

An independent Lead Reviewer has been appointed to oversee the review and produce a report that will be published. The Lead Reviewer will be supported by senior managers from organisations such as Health, Police, and the Council or Children's Trust.

All the organisations who have worked with your child or family will be asked to provide information. Analysis of this information will be included in the final report.

Practitioners and managers involved in the case will also be invited to a meeting to share information and help identify how to improve services and support for children and families in the future.

How are parents and families involved?

We are aware that this is a very difficult time for you but we want to learn all we can for the future.

We believe it is very important that family members share their experience of services and tell us whether anything could have been done better. You are, therefore, invited to meet the Lead Reviewer to discuss any concerns you have about the services you received and to share any things that you feel helped you or your family.

When the review is complete, the Lead Reviewer will arrange to meet with you to share the key learning and to provide you with a copy of the final Report.

If you want to know about any changes that come from the review, you should talk to the Lead Reviewer about how you can hear about these and who can keep you informed of progress.

How long will the review take?

All local Child Safeguarding Practice Reviews should normally be completed within six months of the decision being taken to start the review. Sometimes this timescale needs to be extended.

Publication of the report

The report will not contain any identifying details of your child or family. It will then be published on the internet.

The report will be available to all professionals to ensure that the lessons learned and recommendations made are put into practice.

Key Events Chronology

Date presented as (DD/MM/YYYY):	**Time**	**Source of Information:**	**Contact with the child/young person (state whether they were seen alone or not) and by whom:**	**Contact with family member (state which family member) and by whom:**	**Key Event/Action Undertaken:**	**Comment and Analysis, including potential areas for learning:**

Insert relevant area logo(s) and address here

Date: [insert date]

Dear Safeguarding Lead,

Request to Complete Chronologies for a Safeguarding Review

We are undertaking a local Child Safeguarding Practice Review into the tragic death / serious injury of [insert name of child(ren)]. The first stage of the review process is for each agency to complete:

- a chronology of their agency's involvement with the child and/or their family members; and
- a chronology of organisational changes that may have impacted on frontline practice.

I would, therefore, appreciate it if you could arrange for completion of these two documents.

To support completion, I attach two additional reference documents:

1. A brief 'Case Summary' (this includes an outline of the incident, the family composition, the time period that is the focus of the review and key questions);
2. Guidance Notes on the type of information that should be included in the chronologies.

Individual agency chronologies will be collated to produce an Integrated Chronology which will be used to inform potential learning.

Request to identify staff to attend the Reflective Learning Workshop

Once our information gathering stage is complete, we plan to hold a Reflective Learning Workshop involving **front-line workers and supervisors who had direct involvement with the child and / or their family**. I would, therefore, be grateful if you could identify and confirm the name and contact details of all relevant staff in your organisation.

Submission

Please submit your agency's completed forms via email to [insert name and email address] no later than **[insert deadline].**

If you require any further information or need any support completing the chronologies, please contact [insert name and contact details].

Yours sincerely,

[Insert signature, name and title]

Enc:

- Case Summary
- Chronology Templates – Key Events and Organisational Changes
- Guidance on completing the chronologies

Case Summary

This document should be completed by the manager/administrator of the local Child Safeguarding Practice Review prior to being sent to agencies. It is designed to provide essential reference information to individual agencies when completing their Chronologies and/or Information Report.

This document should be used as a reference when completing the individual agency chronologies and the Information Report.

Background to the Case:

Include here a background summary of the child's death / serious injury.

Child's Details:

Name:
D.O.B:
D.O.D/Serious injury:
Address:

Family Composition:

Additional family members (e.g. grandparents where they are key carers) may need to be added to the table before it is sent out.

	NAME	D.O.B	ADDRESS
MOTHER			
FATHER			
SIBLING			
SIBLING			

Time Period:

The time period covered by the review has been selected to reflect the potential learning likely to be achieved. (There is little value in identifying weaknesses in professional practice or procedures that have already changed). Please focus on this time period when completing your Chronologies and Information Report. **However, do include any Key Events outside of this time period if they are likely to be required to understand the pattern of child neglect and whether early help interventions could have been beneficial.**

Include here time period from the terms of reference

Key Lines of Inquiry:

Include here the Key Lines of Inquiry from the Terms of Reference

Agency Specific Issues:

Include here any agency specific issues that should be considered when completing the Information Report

Guidance for Agencies Completing the Chronologies

Background Information

The Purpose of Child Safeguarding Practice Reviews

Working Together to Safeguard Children 2026 provides a useful summary of the purpose of Child Safeguarding Practice Reviews:

"The purpose of reviews of serious child safeguarding cases is to identify improvements to be made to safeguard and promote the welfare of children. … 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.

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 through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings. These processes may be carried out alongside reviews or at a later stage."

Definition of a Serious Child Safeguarding Case

Working Together 2026 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.

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 (although this is not an exhaustive list). *Working Together 2026* advises that consideration be given to whether impairment is likely to be long-term, even if this is not immediately obvious. Even if a child recovers, serious harm may still have occurred.

Child perpetrators may be the subject of a review, if the definition of a serious child safeguarding case is met.

Purpose of this Guidance

This guidance is intended to provide specific guidance to agencies when asked to complete a Key Event or Organisational Chronology for a Local Child Safeguarding Practice Review. The aim is to ensure a professional standard and consistency across agencies.

Who should complete the Chronology?

Chronologies should be completed by **a senior member of staff who has had no involvement with the case.** This individual should have access to all relevant information and records relating to the case and should be given the opportunity to query facts with staff where necessary.

A Senior Officer within the agency should **quality assure and sign off the chronology** prior to its submission.

Further advice and support is available from [insert contact details of individual able to provide advice and support].

Purpose of the Chronologies

What is a Chronology?

A chronology is a succinct summary and overview of the significant dates and events in a child's / young person's life. Chronologies are also used to capture significant organisational changes.

When undertaking a local child safeguarding practice review all relevant agencies will often be asked to complete a 'Key Events Chronology' of their agency's involvement **and** a chronology of any organisational changes which may have impacted on frontline practice during the same period.

Individual agency chronologies will be collated to produce an Integrated Chronology. (This will often be colour coded to facilitate an 'at a glance' overview of agency involvement.)

Why are Chronologies Useful?

Children and young people are most effectively safeguarded if professionals work together and share information. Single factors in themselves are often perceived to be relatively harmless. However, if these factors multiply and compound one another, the consequences can be serious, and on occasions, devastating.

Chronologies are used as an analytical tool to help understand the impact of events and changes on a child / young person's developmental progress. They can reveal risks, concerns, patterns and themes, strengths and weaknesses within a family, and can identify periods of professional involvement, support and its effectiveness. Chronologies enable the Review Team to gain a more accurate picture of the whole case and highlight gaps and missing details that require further assessment and identification.

It is recognised that the relevance and / or significance of an event can change over time. A historical event which appeared insignificant or irrelevant at the time may become highly significant in the light of further information or subsequent events.

How to Complete a Chronology

What is a Key Event Chronology?

A 'key event' is a significant incident that impacts on the child's / young person's safety and welfare, circumstances or home environment. This will require a professional decision and / or judgement based upon the child / young person and family's individual circumstances.

It is crucial that the information recorded in a chronology is **relevant and succinct** to avoid key events becoming lost in a mass of insignificant and irrelevant detail.

The events or incidents that should be recorded will vary from case to case depending upon the nature of the risks and harm. The following are some examples but this is not an exhaustive list:

- Contacts or referrals about the child / young person / family;
- Assessments undertaken;
- Strategy Discussions;
- Meetings and Child Protection Conferences;
- Child Protection enquiries and Section 47 investigations;
- Non-accidental injury and significant injury or neglect events;
- Attendance / admittance to hospital;
- Births, deaths, serious illness of adults and children and young people in the family;
- House moves;
- Changes in family composition, including new partners, separations, non-family members moving into family home;
- Criminal proceedings and outcomes;

- Civil proceedings involving the family;
- Change in school and school exclusions;
- Change in GP;
- Self-referrals and any referrals to other agencies / teams;
- Court proceedings and changes in legal status, including periods when a child / young person became looked after by the local authority;
- Police logs detailing relevant incidents at family home or in relation to family members, such as reported incidents of domestic abuse, drunken / anti-social behaviour;
- Child / young person's absconding behaviour / missing from home;
- Attempted suicide or overdose of child / young person or family member;
- Specific support offered to family;
- Events showing capacity of family to work in partnership and engage with professionals;
- Frequent presence of unknown adults;
- Any event in the child's life deemed to have a significant effect on them, such as separation from main carer leading to poor attachment.

What Time Period should the Chronology Cover?

The time period covered by each review will be identified based on the potential learning likely to be achieved. There is little value in identifying weaknesses in professional practice or procedures that have already changed. All agencies will be informed of the relevant timeline when asked to complete the chronology template: this will usually be included in the 'Case Summary' provided or the Terms of Reference. Please focus on this time period when completing your chronology. **However, do include any Key Events outside of this time period if they are likely to be required to understand the pattern of child neglect and whether early help interventions could have been beneficial.**

In some cases a chronology for a child / young person may start with events that occurred prior to his or her birth.

Why Do I Also Need to Complete a Chronology of Organisational Changes?

The purpose of a local Child Safeguarding Practice Review is to identify improvements to current safeguarding arrangements to prevent, or reduce the chance of, similar incidents in the future. Improvements may be linked to practice issues but they frequently also require changes to the organisational and "systems" factors that shaped behaviour (such as organisational/team aims or culture and the level of resources available to deliver services.)

The chronology of significant organisational changes is, therefore, important to help to identify where organisational and "systems" factors influenced actions.

Again, it is crucial that the information on organisational changes recorded in a chronology is **relevant and succinct** to avoid key events becoming lost in a mass of insignificant and irrelevant detail.

NOTE: Disclosure of Chronologies
Agencies should be aware that a request may be made by the Police or Court for chronologies to be disclosed when information is being gathered for a criminal case. If requested, we will not provide a copy of your documents but will, instead, forward your contact details to the Officer seeking disclosure so that direct contact can be made.

Case to be escalated by the Independent Scrutineer

Request for this to be considered for a Local Lessons Learned Review.

[INSERT INFORMATION AND CONCERNS RE CASE: including family ID etc]

Background information
[INSERT ALL BACKGROUND INFORMATION]

Request
There is potential learning for one or more agencies as a result of their involvement with this child/ these children (delete as necessary). I am of the view that this could be undertaken as a local lessons learned review …….

Insert relevant letterhead here

Date: [insert date]

Dear Colleague,

Reflective Learning Workshop – [Insert Date]

We are undertaking a local Child Safeguarding Practice Review regarding [insert name of child(ren) / where appropriate the serious incident and date]. The purpose of the review is to identify improvements to current safeguarding arrangements to prevent, or reduce the chance of, similar incidents in the future.

We recognise that first-hand experience from those working with the child and their family is essential to ensure we have a full understanding of both the case and the factors or pressures that caused people to act as they did. All professionals who have had **direct involvement** with the child and/or family are, therefore, being invited to attend a Reflective Learning Workshop.

Insert here the date, timings and venue of the Reflective Learning Workshop

This will be an opportunity for professionals from different agencies to discuss why things happened, or did not happen, and what could be done differently in a respectful, positive and supportive environment. **As a professional involved in the case it is important that you attend.** If you are unable to attend for any reason, please let me know and I will make arrangements for you to participate in another way (such as a one-to-one meeting with our Lead Reviewer).

We also plan to hold a feedback session towards the end of the review process and would appreciate if you could hold [insert date and time] in your diary.

I enclose a one-page briefing which explains more about the purpose and structure of the workshop. However, if you have any questions or concerns, please do not hesitate to contact [insert name and contact details].

Kind regards,

[Insert name and signature of relevant individual. This may be the Chair of the CSPR Group, the Lead Reviewer, or the Manager responsible for overseeing the process.]

About the Reflective Learning Workshop

The purpose of a local Child Safeguarding Practice Review of a serious incident is to identify improvements to current safeguarding arrangements to prevent, or reduce the chance of, similar incidents in the future. It is NOT looking to attribute blame to individuals or organisations.

The Reflective Learning Workshop is a crucial part of the review process. This (usually half-day) meeting provides a forum for frontline professionals and operational managers to come together in a respectful, positive and supportive environment to consider the circumstances surrounding the case and the reasons actions were taken.

Important Principles

- **The workshop will provide a supportive environment that encourages reflection**

  The meeting will be led by an independent Lead Reviewer for the case. All Lead Reviewers are expected to ensure the workshop provides a respectful and supportive environment and they will intervene if anyone starts discussing blame or focusing on individual practice.

- **All observations and comments will be anonymous**

  We understand that participants may feel uncertain or anxious and would like to assure you that comments made on the day will not be attributable to individuals. Any themes and comments will be anonymised in the final report.

- **We will be capturing good practice as well as what needs to change**

  While the focus of the review is to identify ways to improve safeguarding practice, the review will also be seeking to identify where practice is good and working well.

  The Structure of the Workshop

  The structure of the workshop will vary depending on the case but is likely to follow the following format:

- **Considering the Factual Information**

  The Lead Reviewer will give an overview of the key facts and events in respect of the case and participants will be asked to agree/change and discuss these. This may include querying the factual accuracy, adding to the information, or questioning it. The aim is to reach an understanding of the professional intervention and key events that the child and family experienced.

- **Considering the Child's Lived Experience**

  With this knowledge, the workshop group will spend a short time exploring the "lived experience of the child/children". The enables participants to view what happened from the child's perspective.

- **Identifying Key Issues and Themes**

  The workshop will identify and discuss the key issues and themes. These will usually be practice issues that have emerged within the case which can be transposed into working with families more generally, and/or organisational and "systems" factors that shaped behaviour (such as organisational/team aims or culture and the level of resources available to deliver services).

- **Identifying Learning**

  The final part of the workshop will focus on identifying areas of learning for professional practice in the future. Examples of good practice will also be highlighted and included for wider dissemination in the review report.

Insert relevant area name and logo(s) here

Reflective Learning Workshop

Date / Time
Venue
Agenda

No	Time	Item
	9:45am	**Registration**
1.	**10:00am**	**Welcome and Introductions**
2.	**10:05am**	**Purpose of Session:** • *To understand the child's story and what life was like for them;* • *To consider what happened in the case from a multi-agency practitioner and agency perspective;* • *To identify what decisions were taken/not taken and the context;* • *To identify what could have been done differently;* • *To identify the key learning points/findings;* • *To identify improvements which are needed and to consolidate good practice, in line with the Terms of Reference.* **Principles for Working Together**
3.	**10:20am**	**Brief Outline of Terms of Reference, Methodology / Overview of the Case and Thoughts so Far - (*Lead Reviewer)*** **Child's Lived Experience (Timeline/story)**
4.	**11:00am**	**Agency Involvement with the Case:** • Who knew what when? • What is new information? • Any surprises? ➢ What? ➢ Why? • Significant Influencing Factors?
5.	**11:30am**	**Break**
6.	**11:45am**	**Key Lines of Inquiry and Questions** *Identify Key Issues for Improving Practice*
7.	**12:40pm**	**Summary of Key Feedback Points and Any Other Reflections**
8.	**13:00pm**	**Evaluation and Close**

Reflective Learning Workshop

Worksheets

Please read and use this workbook in line with the guidance note that you have been sent about the Reflective Learning Workshop.

Although it is anonymised this workbook contains confidential information and should not be shared outside the review process. It should be returned when completed to [insert appropriate contact details here].

If possible, print off a copy to use in the meeting. Please write your thoughts in the response book as we go through the Meeting. You will have time at the end to finish adding your thoughts.

We want to hear from you about your experiences of working with [insert name(s) of subject(s) of the review] at the time and about any systemic issues which were affecting you or your agency and which may have impacted on the work: Try and capture what worked well and what the challenges were.

- What influenced the actions or hindered them? Systems issues?
- Why did things happen or not happen?
- Was this case unique or how common is it?
- If, on refection of your work, you have learned how you or agencies systems could or should have done something differently – let us know.
- Have we identified the right lessons from this case?
- How similar is this case to others?

Only the Review Panel will see these private responses – they are private to you and the Panel. The Panel will not see who has shared what responses. The lessons from them will be shared anonymously and summarised into the final report.

If a court of law asks for access to them, they may be disclosable.

Please add sheets if you need to, clearly numbering the questions your responses relate to.

Please sign and date the confidentiality statement:

I understand that the information about this case and in the meeting in which I shall take part remains highly confidential. I will not store it, or share it, in any form, except for conversation with those in my agency or the Partnership who have a right to know.

Signed: Date:

Your name and contact details:

Name: Agency:

Email: Phone:

Thank you for your assistance in this learning process. It will enable us to achieve a better understanding of the case and local systems so that we can seek to improve the way we safeguard our children.

Worksheet 1

To be completed before the meeting

The reason for asking you to do this before the meeting is to capture your thinking before you are influenced by the Panel's thinking or by hearing from others.

1. **What was your role in this case?**

2. **Thinking back to your involvement at the time what did you think that the key issues were in supporting and safeguarding [insert name of subjects of review]?** Challenges and strengths? Systems issues?

3. **What worked well and why?**

4. **Were there any problems in service delivery? If so, what were they? What caused them? About the family, about the agency or about the wider child welfare system. Have they now been resolved? If so, how?**

5. **Have you reflected on the case and your involvement of the involvement of others since the tragic outcome? If so, what have you thought, learned or asked?**

Worksheet 2

Please use this worksheet in the meeting itself to capture your thinking, or new questions in response to what is shared with you. You will have a chance to speak as well and so you may not need to write everything down. If there are things you do not want to say in the group as a whole, you can include them here.

The Lead Reviewer will share the timeline of key contacts from all agencies in summary as we know them.

Please note any inaccuracies, any gaps or explanations if you have them. Also note your questions. The timeline will be shared in phases with an opportunity for comments and questions between each phase. The phases will be numbered – please number your responses.

Responses to the Summary TimeLine and learning or questions arising from it: Phase 1 (etc)

Worksheet 3

Responses to the Proposed Lessons / Findings,

suggestions for any additional lessons,

or any other questions you may have

Please use this worksheet in the meeting itself to capture your thinking, or new questions in response to what is shared with you. You will have a chance to speak as well and so you may not need to write everything down. If there are things you do not want to say in the group as a whole, you can include them here.

The Lead Reviewer will share the possible emerging lessons that the Panel has

identified. Do they match your own experience? Are they accurate and reasonable?

Do they apply to just this case or wider across more cases?

Have you identified any additional lessons?

Please put your response to each lesson below. They will be numbered on the screen.

Proposed lesson 1 (etc)

Worksheet 4

Feedback on this learning process as part of the review

It would help us to plan similar events to get your feedback on this process.

What worked? What could have been improved?

1. Did you have enough information in advance to explain the purpose and process of the meeting? (Too much?)

2. Could anything more have been done to help you prepare?

3. Were you supported? What helped that or what prevented that?

4. Were you able to contribute to the meeting? What helped and what hindered?

5. Do you have any additional thoughts that could have improved this process?

6. Would you like to speak privately with the Lead Reviewer/s?

1. Background

National research and analysis of both reports for Serious Case Reviews (the predecessor to Local Child Safeguarding Practice Reviews) and reports produced for Local Child Safeguarding Practice Reviews (LCSPRs) repeatedly highlight the variation in the format and quality of the final reports.

The structure of final reports for LCSPRs will need to vary according to the individual case being reviewed. However, this brief guidance document highlights the key elements that Safeguarding Partners in the wider West Midlands will expect to see in the reports they commission.

2. Minimum Requirements

Reports should be focused and succinct, with relevant, clear content from which the analysis, learning and conclusions logically and explicitly flow. The report should give a sense of the distinct context for the child and what their daily life was like. It should speak to front-line practitioners as well as leaders and senior managers.

Reports should be written in a way that avoids harming the welfare of any children or vulnerable adults in the case. The author of the report (normally the Lead Reviewer) should ensure information is appropriately anonymised (see section 3.1 below) and is written with publication in mind.

Where the views of surviving children or family members have not been included in the review, a short statement should be included detailing the reasons why.

Every LCSPR should have clearly framed questions that the review seeks to answer. Reports should address these questions and meet any other requirements specified in the agreed Terms of Reference. As a minimum, the report should also succinctly include:

- a brief overview of what happened and the key circumstances, background and context of the case. This should be concise but sufficient to understand the context for the learning and recommendations;
- an analysis of why relevant decisions by professionals were taken, including the conditions in which practice took place;
- a critique of how agencies worked together and any shortcomings in this;
- whether any shortcomings identified are features of practice in general;
- what would need to be done differently to prevent harm occurring to a child in similar circumstances;
- examples of good practice, and
- what needs to happen to ensure that agencies learn from this case. (This should include local learning as well as any implications for national policy and practice).

3. Good Practice

When drafting reports, it is worth considering the following:

3.1 Language and terminology

- Reports should be written clearly in plain English.
- A glossary can be helpful as a check for unfamiliar terms and acronyms (although not when a wide range of acronyms are used). Authors of reports should be aware that acronyms for local organisations make little sense to those reading the report beyond the local area.
- Reports should be written in a way that avoids harming the welfare of any children or vulnerable adults in the case. Information should be appropriately anonymised and very intimate and personal detail of the family's life should be kept to a minimum to reduce the sensitivity of

publication.

- The names of the child who is subject of the review and their family members should be anonymised in a way that ensures the report remains easy to read. For example, reports where each family member is given a reference letter or number can be hard to follow. It is frequently easier to follow the report's narrative when the child is given a pseudonym and family members are referred to by their relationship to the child e.g. Mother, Father, Stepmother, Maternal Grandfather, Sister, Brother etc.

3.2 Structure of the Report

- The inclusion of a 'Contents' page can make reports more accessible to the reader.
- Similarly, the National Child Safeguarding Review Panel recommend the inclusion of an executive summary of no more than 2 A4 pages.
- Reports should be as short as possible to meet the requirements outlined above. Only relevant information should be included.
- The provision of a concise summary of relevant family history and past agency contact can help provide a context for understanding how the past affected events and aid the understanding of why and how the child died or was seriously harmed.
- Having a dedicated section about the child frequently provides the report with a strong focus and ensures the child's voice is considered.
- Repetition of events often gets in the way of analysis. For example, when detailed accounts of agency involvement are included and then revisited as part of the analysis. The reader should not, however, be required to constantly cross-reference to other parts of the report.

3.3 Analysis

The purpose of a LCSPR is to **analyse** the case not simply to describe what happened. This includes asking questions such as:

- Why were key decisions made?
- Why were critical observations missed or simply ignored?
- Why did circumstances exist which caused sometimes terrible detriment to one or more children?

The focus should be on what caused something to happen and how it can be prevented from happening again. Lead Reviewers and Review Teams should probe behind the first information or first answers they are given, whether from service users or other practitioners. Their analysis of events should ask these 'second questions' in order to get the heart of what was missing, why and how change can be achieved.

Systems factors should be considered. This includes policies, procedures and organisational changes as well as leadership, culture, and human motivations (such as the impact of fear, exhaustion, overwork etc.). The review should consider relevant failings and good practice and policy at all levels.

Many strong reports explicitly flag where the analysis highlights a learning point (e.g. by stating 'Learning Point 1'). This can help make the link between the analysis and the learning points / recommendations.

3.4 Learning Points / recommendations

This learning should be identified separately in the final report, before any recommendations. The report should also explain the link between the learning identified and the specific recommendations.

It can be useful to use headings that sum up the emerging themes and learning points. (For example, 'Inter-agency communication' or 'The use of written agreements.')

Some areas in the wider West Midlands may choose to convene a dedicated group to consider how learning points are developed into meaningful recommendations. Lead Reviewers should check the approach being taken.

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.

Recommendations should be clear and addressed to named people or organisations locally and nationally. They should clearly articulate how change might come about and how the effectiveness of any change in practice will be assessed and measured.

4. Checklist – Quality Markers

The Social Care Institute of Excellence / NSPCC 'Quality Markers' include seven questions that reviewers may wish to consider when drafting their report:

- Does the structure of the report make it straightforward to identify relevant analysis and findings, so as to assist other local areas to identify learning that is pertinent to them and to assist the collation of learning at a national level?
- Does the amount of information provided in the report satisfy the need for privacy of family members and individual staff while providing sufficient information to make accessible the analysis, in order that it can support necessary improvement work?
- Does the report contain findings and/or recommendations that reflect the areas deemed as priority for improvement?
- Do these findings and/or recommendations address explanations of practice or remain only descriptive of issues identified in how professionals handled the case?
- Is there transparency in how conclusions have been reached?
- Does the report adequately manage accessibility and explaining complex professional and organisational issues?
- Is the tone and choice of words appropriate to the review?

LEARNING FROM CHILD SAFEGUARDING PRACTICE/RAPID REVIEW: CHILD X ACTION PLAN							
Issue	**Action(s)**	**Lead**	**Timescale**	**Desired Outcome**	**Progress Updates**	**Completion (RAG)**	
Barnsley Hospital NHS Foundation Trust (BHNFT)							
1.	1.a						
2.	2.a						
3.	3.a						
Barnsley Children's Social Care (CSC)							
4.	4.a						
5.	5.a						
6.	6.a						
Barnsley Early Help							
7.	7.a						
8.	8.a						

9.		9.a						
Barnsley ICP including Primary Care								
10.		10.a						
11.		11.a						
12.		12.a						
South West Yorkshire Foundation Trust- Mental Health (SWYFT)								
13.		13.a						
14.		14.a						
15.		15.a						
16.		16.a						
South Yorkshire Police (SYP)								
17.		17.a						
18.		18.a						

19.		19.a						
Barnsley 0-19 Public Health Nursing Service (0-19PHNS)								
20.		20.a						
21.		21.a						
22.		22.a						
Barnsley Safeguarding Children Partnership (BSCP)								
23.		23.a						
24.		24.a						
25.		25.a						
26.		26.a						
27.		27.a						
28.		28.a						
29.		29.a						

30.		30.a						
31.		31.a						
32.		32.a						
33.		33.a						
34.		34.a						
35.		35.a						

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