City of York
Safeguarding Children Partnership

City of York Children's Safeguarding Partnership Case Review Practice Guidance

City of York Safeguarding Children Partnership Case Review Procedure

Title	**City of York Safeguarding Children Partnership Case Review Practice Guidance**
Version	**4.0**
Date	
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Update and Approval Process			
Version	**Group/Person**	**Date**	**Comments**
1	Sophia Lenton-Brook Clare Davies		
2	Jacqui Hourigan Sophia Lenton-Brook	September 2022	Review of guidance
3	Case Review Sub-Group	May 2023	Taken to Case Review Sub-Group for comments/approval
4	Case Review Sub-Group	May 2023	Approved
5	References to Working Together 2018 updated to 2023	August 2024	

Issue Date	**24/05/23**
Review Date	**24/05/25**
Reviewing Officer	**City of York Safeguarding Children Partnership Business Unit**

City of York Safeguarding Children Partnership Case Review Procedure

Who is the Guidance for?

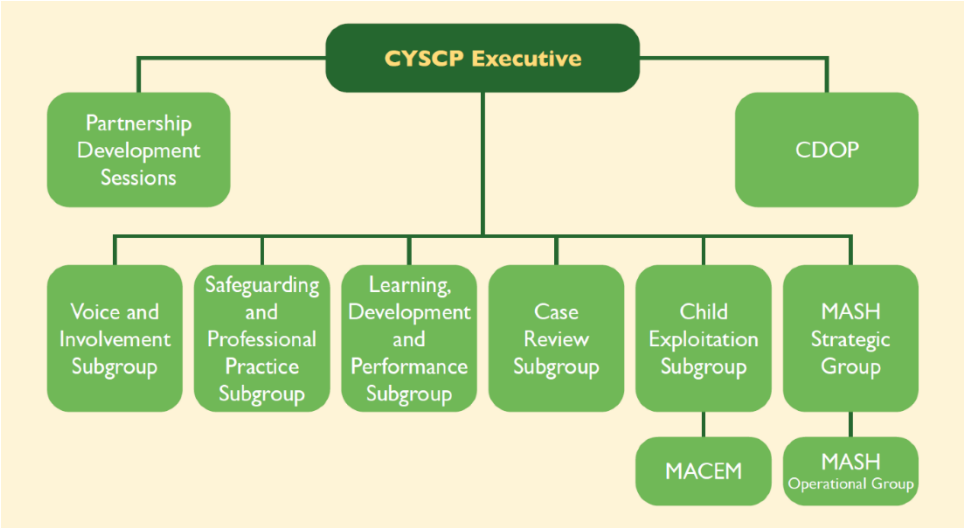
This practice guidance should be adhered to by all partner agencies of the Safeguarding Children Partnership. The guidance is particularly aimed at those involved in undertaking or contributing to Rapid Reviews, multi-agency reviews or Local Child Safeguarding Practice Reviews (CSPRs), such as the three key statutory partner agencies, Independent Lead Reviewers, Case Review Subgroup members and Panel members, those providing information on behalf of their organisation as well as those responsible for quality assuring and embedding the learning from the review process.

This practice guidance should be read alongside the relevant statutory guidance set out in Working Together to Safeguard Children (2023) and the non-statutory Child Safeguarding Practice Review Panel guidance for safeguarding partners.

In the event of a child death, this framework must be read alongside the Child Death Review: statutory and operational guidance (England) 2018. Although information gathering can be commenced for the Child Death Overview Process, any Rapid Review, multi-agency review or CSPR must be concluded prior to consideration or conclusion at the Child Death Overview Panel.

City of York Children Safeguarding Arrangements

The Children Act 2004, as amended by the Children and Social Work Act 2017, and the associated statutory guidance Working Together to Safeguard Children (2023) replaced Local Safeguarding Children Boards (LSCBs) with new local Multi-agency Safeguarding Partnership Arrangements (MASA). The new MASA arrangements placed new duties on the three Statutory Safeguarding Partners (namely: the Local Authority, the Police and the Clinical Commissioning Group) in local areas, to make arrangements to work together, and with other relevant agencies locally. Within the City of York the agreed governance arrangements are as follows:



The functions of the Case Review Subgroup

The Case Review Subgroup, in accordance with Working Together to Safeguard Children (2023) is responsible for identifying serious safeguarding cases which raise issues of importance to improve Child Protection and Safeguarding Practice within the City of York. The Chair of the Case Review Subgroup also has a responsibility to provide assurance to the CYSCP Executive on a quarterly basis on the business actions and outcomes of the group.

The purpose of child safeguarding practice reviews as set out in Working Together (2023) at both local and national level, is to identify improvements to practice and safeguard children and promote the welfare of children.

Where a serious child safeguarding case has been identified the local authority have a duty to notify the Child Safeguarding Practice Review Panel within five working days of becoming aware that the incident has occurred (Working Together, 2023 Chapter 4 page 86).

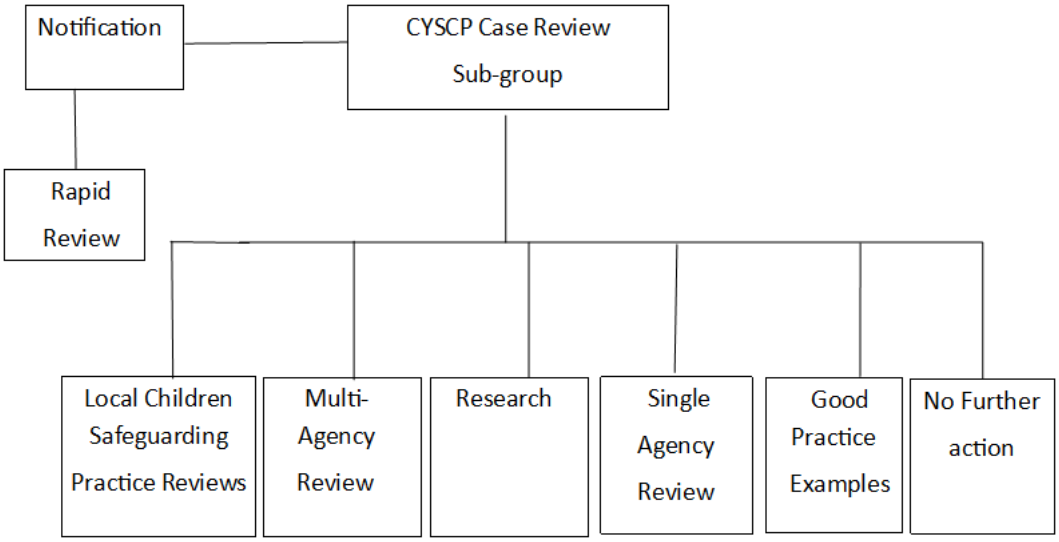
The Case Review Subgroup will instigate the rapid review process upon a notification being made by the local authority and comply with the requirements of the Child Safeguarding Practice Review Panel (The Panel) about whether a Local or National review is required. Rapid reviews should be submitted to the Panel within 15 working days of the incident.

The Case Review Sub-Group members are also responsible for identifying and submitting cases to the Case Review Group for consideration where the case may not meet the definition of a serious child safeguarding case but nevertheless raise issues of importance to the City of York that might, for example, include where there has been good practice, poor practice or where there have been 'near miss' events (Working Together, 2023).

The Case Review Sub-Group are responsible for commissioning and publishing (where appropriate) local Child Safeguarding Practice Reviews, multi-agency reviews and single agency reviews.

The Case Review Sub-Group should review any national, regional or local learning and develop learning resources such as briefings, one minute guides and reports which can be disseminated to front line professionals, partners and stakeholders.

Outcomes following case discussions are as follows:



Local Procedure for Rapid Reviews

CRITERIA FOR SERIOUS SAFEGUARDING REVIEW (CHAPTER 4 WORKING TOGETHER 2023 pp 83-86)

Serious child safeguarding cases are those in which:

abuse or neglect of a child is known or suspected ***and***

the child has died or been seriously harmed

The criteria which the local 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 which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate

Safeguarding partners 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 clinical commissioning group 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

Some cases may not meet the definition of a 'serious child safeguarding case', but nevertheless raise issues of importance to the local area. That might, for example, include where there has been good practice, poor practice or where there have been 'near miss' events. Safeguarding partners may choose to undertake a local child safeguarding practice review in these or other circumstances.

Identification

Where a serious child safeguarding case is identified by a professional i.e., abuse or neglect of a child is known or suspected, **and** the child has died or been seriously harmed. For a definition of harm refer to the Child Safeguarding Practice Review Panel guidance for safeguarding partners.

The professional must discuss this with their safeguarding lead/senior manager who will inform the CYSCP: CYSCP@york.gov.uk

Notification

The local authority must notify any event that meets the above criteria to the National Panel and must do so within five working days of becoming aware that the incident has occurred.

The local authority should also report the event to the safeguarding partners in their area within five working days. Where a looked after child has died, whether or not abuse or neglect is known or suspected. The local authority must also notify the Secretary of State and Ofsted.

Rapid Reviews

On being informed of a notifiable incident, safeguarding partners will undertake a Rapid Review within 15 working days following a notification being made to the National Panel. This is in line with published guidance in Working Together to Safeguard Children (2023) and the non-statutory Child Safeguarding Practice Review Panel guidance for safeguarding partners. In order to make decisions and to inform the initial

recommendation to the three statutory partners who will ultimately recommend to the National Panel about whether a Local Child Safeguarding Practice Review is required. The CYSCP Business Unit are responsible for convening and co-ordinating a Rapid Review meeting which will normally take place within 7-10 days of a notification being made. This will allow reporting to the National Panel to take place with the 15 working day time period. The Rapid Review will be attended by Case Review Subgroup members along with any other relevant agency. identified

A Form 2 will be circulated by the CYSCP Business Unit prior to the Rapid Review Meeting to all agencies who have had involvement within the case and may hold information This information will be returned to the CYSCP Business Unit within 3-5 working days of the request, in order for information to be combined and re-circulated back out to partners in preparation for the Rapid Review meeting to take place.

The CYSCP Business Manager and Chair of the Rapid Review Meeting will meet in advance of the meeting to consider the information submitted by agencies and to identify key practice episodes.

The Child Safeguarding Practice Review Panel guidance for safeguarding partners issues advice on conducting raid reviews which includes that as a minimum that the Rapid Review records:

- 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
- Family structure and relevant background information on the family – include all children not just the one(s) harmed or who died. A family tree (genogram) is often helpful. Relevant information should be provided on the parents and any significant adults, including ages and any known physical or mental health problems or disability.
- Immediate safeguarding arrangements of any children involved
- Whether or not the case in question is being considered against the criteria set out in Working Together (2023);
    - Immediate safeguarding arrangements of any children involved
    - A concise summary of the facts, so far as they can be ascertained, about the serious incident and relevant context; this should give sufficient detail to underpin the analysis against the Working Together criteria, but does not require lengthy detailed chronologies of agency involvement that can obscure the pertinent facts
    - A clear decision as to whether the criteria for local child safeguarding practice review have been met and on what grounds, and if not, why not. Clear reasons are required
    - A recommendation on whether or not a national review would be considered necessary, and if so, why. Clear reasons are required
    - Any immediate learning already established and plans for their dissemination
    - Potential for additional learning
    - If the decision is taken not to proceed with a local child safeguarding practice review, a summary of why it is thought there is no further learning to be gained

- Which agencies have been involved in the rapid review, explaining any agency omission whose involvement would be usually expected
- Who has been involved in the decision-making process, and
- Relevant identifying details of the child and family.

Additional issues that the National Panel states is important to consider in rapid reviews includes:

- What was the child's true lived experience and how can their voice be heard in the review?
- How was the race, culture, faith, and ethnicity of the child and/or family considered by practitioners and did cultural consideration impact on practice?
- How did any disability, physical or mental health issues, and any identity issues in the child and/or family impact on the child's lived experience and on practice?
- Were any recognised risk factors present or absent and did they play a significant part in the child's lived experience?
- Can any relevant national reviews be referenced and used to support local learning?
- Are there issues identified that are of national significance? Is a national review considered to be necessary following the rapid review? If so, why?
- Are there sufficient and sound reasons to proceed with an LCSPR? If it is decided to proceed with an LCSPR, an appropriate scope should be specified, with some identified key lines of enquiry.
- Does the review identify relevant good practice, and should this be disseminated across the system?
- Has the review identified clear agency and partnership actions to take forward, especially where there is no LCSPR recommended?

Following the Rapid Review meeting it is the responsibility of the Rapid Review Chair with support from the CYSCP Business Manager to write a Report using the Form 3 template. They are responsible for meeting with the three statutory partners to discuss the outcome of the Rapid Review and the recommendation made by the Rapid Review Panel Members.

The three statutory partners have the final decision as to what recommendation will be made to the National Panel; regardless of any recommendation made at the Rapid Review Meeting.

Deciding whether to conduct a Local Child Safeguarding Practice Review

It is for safeguarding partners to determine whether an LCSPR is appropriate, considering that the overall purpose of a review is to identify improvements to local practice and wider systems. Just because an incident meets the criteria for notification in Working Together (2023) does not mean there is an automatic expectation to carry out an LCSPR.

Safeguarding partners need to be clear from the outset what the benefit would be of conducting an LCSPR following on from a quality rapid review. Rapid reviews should

always set out a very clear rationale for doing an LCSPR and should be explicit about the key questions that the LCSPR would seek to answer.

Good practice LCSPRs identify new learning that is not yet available in local safeguarding systems, or they tackle perennial problems that need further or perhaps different attention. An LCSPR does not automatically explore learning from a rapid review in more detail although partners may decide to initiate an LCSPR for this reason.

If a child has been notified and the rapid review subsequently identifies that the notification criteria is no longer met (for example, there is no evidence of abuse or neglect, or the harm suffered was deemed not to be serious), the safeguarding partners may nevertheless decide to carry out an LCSPR if they deem that there is still potential for further learning and a clear rationale for doing so.

It is important to remember that the responsibility for decision making rests with the safeguarding partners therefore it is important to document who participated in the rapid review to ensure that the executive leads 'own' the decision. Where that responsibility has been delegated it is important to be clear on the lines of accountability. While the views of the independent scrutineer are valuable, they do not replace the responsibility of the safeguarding partners.

Occasionally the Panel may question the decision to conduct an LCSPR if we do not feel there is sufficient justification or information about need for further review.

Similarly, the Panel may question a decision not to conduct an LCSPR if it feels that the rapid review has not adequately explored the learning or if there may be further learning to be gained from an LCSPR.

Informing the National Panel of Decision

As soon as the Rapid Review is complete, the CYSCP Business Manager is responsible for submitting the response to the National Panel. The National Panel will then review the case at a meeting (normally within 10 working days) and the outcome of their final decision will be made normally within 10 working days.

It is the responsibility of the CYSCP Business Manager to share the outcome of their decision with the three statutory partners, the Independent Scrutineer and the chair of the Case Review Subgroup and its members.

Local Safeguarding Practice Review

Following the Rapid Review process if a Local Child Safeguarding Practice Review has been agreed then the Case Review Sub-group will be responsible for commissioning and supervising reviewers taking into account:

- Professional knowledge, understanding and relevant experience
- Knowledge and understanding of research
- Any conflict of interest
- Criteria as described in WT 2018 (pp 89)

- will agree terms of reference and methodology, and the timeline for completion of the review, with the reviewer. The Case Review Subgroup will support the reviewer to ensure that satisfactory progress is being made and quality maintained. The Case Review Subgroup will also make certain that:
- Practitioners are fully involved and contribute their perspective
- Families are informed and invited to contribute to reviews.
- Consideration has been given to utilising advocacy when capturing the views of children and young people during the review process or of parents with learning difficulties or disabilities.

The Case Review sub-group will quality assure the draft and final version of the review to ensure that the final report contains analysis, a summary and recommendations for further action with relevant agencies identified and focussed on improving outcomes for children.

- 'In the Panel's opinion, a 'good' report is one that sets down:
  - 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
  - A summary of why relevant decisions by professionals were taken
  - A critique of how agencies worked together and any lessons learnt to improve this identified
  - Whether any potential improvements in practice identified are features of practice in general
  - What would need to be done differently to prevent harm occurring to a child in similar circumstances
  - What needs need to be undertaken to ensure that agencies learn from this case; and
  - Views of family and children clearly described.

Multi-Agency Reviews

The Case Review Sub-Group members are also responsible for identifying and submitting cases to the Case Review Group for consideration where the case may not meet the definition of a serious child safeguarding case but nevertheless raise issues of importance to the City of York that might, for example, include where there has been good practice, poor practice, have identified multi-agency learning or where there have been 'near miss' events (Working Together, 2023).

Where a practitioner believes that a case merits discussion at the Case Review Subgroup Meeting, they should discuss this with the safeguarding lead in their agency. Following the discussion, the Case Review Member within their agency should be notified. The Case Review member should then submit a Form 1 to the CYSCP Business Unit: CYSCP@york.gov.uk

On receipt of information the Chair of the Case Review Subgroup Member in discussion with the safeguarding lead for the referring agency to review the Form. If it has been identified that this case should have been notified to the National Panel then the three

statutory partners will be notified. If however, it does not meet the creteria but learning has been identified then this case will be discussed at the next Case Review Subgroup Meeting. As part of this process agencies may be asked to bring case information they may hold to the meeting or a request will be made via the CYSCP Business Unit to complete a Form 2 in preparation of the meeting.

Following a case discussion, it may be identified that either a multi-agency review, single agency review or no further action is required. The outcome and decision making will be the responsibility of the Case Review Subgroup members. The Chair of the case review subgroup will be responsible in sharing the outcome with the three statutory partners via the quarterly assurance report to the Executive,

Findings from these cases will be used to inform decisions about audit themes; to be incorporated into safeguarding training courses; and/or to be disseminated within organisations by their representatives.

Actions agreed from such case discussions will be included in the Case Review Action Log for review at the Case Review meetings.

Escalation process

Professional concerns and disputes can arise at any stage of the child protection process and can lead to ineffective multi-agency working or in rare cases dangerous practice.

If professional disagreements remain unresolved, the matter must be referred to the Head of service for each agency involved.

The CYSCP does not intervene in individual cases other than in exceptional circumstances when the case is approaching the threshold for consideration for a Child Safeguarding Practice Review:

In the unlikely event that the steps outlined above do not resolve the issue, and/or the discussions raise significant policy issues and/or a number of similar concerns or disagreements have been recorded, so that the case meets the criteria outlined in Chapter 4 of Working Together 2023 for consideration for a Child Safeguarding Practice Review, the matter can be referred to the three Statutory Partners via the CYSCP Business Manager. Those criteria state that 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

The three statutory partners may decide to refer the case to the Case Review Group for possible consideration for a case review.

Where a matter is referred to the Case Review Subgroup, members will make a decision about whether the case meets the criteria for a further review.

The CYSCP have a separate Resolution of Disputes practice guidance which can also be reviewed inline with this guidance.

CYSCP Monitoring and Learning

The Case Review Subgroup is responsible for ensuring that any actions, learning points or recommendations are monitored. All Case Review Subgroup Members are responsible for ensuring that actions are completed by their individual agency.
The Case Review sub-group is responsible for ensuring any learning from all cases is disseminated throughout the Partnership. This includes any national or regional learning.

Learning can be disseminated as follows:

- CYSCP Learning Masterclass briefing sessions
- One Minute Guide's
- 7 point briefings
- Updates to Policies and Procedures
- Updates on the website
- Training Sessions
- Newsletter

Each member of the Case Review Sub-group is responsible for disseminating any learning from meetings, reviews, good practice examples etc to professionals/frontline workers within their respective organisations.

Members of the Case Review Sub-group need to provide assurance to the Partnership that learning has been disseminated and shared and provide examples of impact on practice.

Process

If the Partnership commission a review the CYSCP has responsibility to:

- Develop Terms of Reference for the review which is signed off by the three statutory partners and the Executive
- The Case Review Sub-group has responsibility for commissioning an independent author
- Identify the scope of the review
- Request agencies to provide information pertaining to an individual child and/or family following an internal review of each agencies records
- Request partners agencies to complete a chronology proforma and on some occasions to complete an IMR report template ensuring critically reflective analysis of the appropriateness and quality of decision making and actions against the terms of reference
- Meet with the family involved to gain their views and feedback

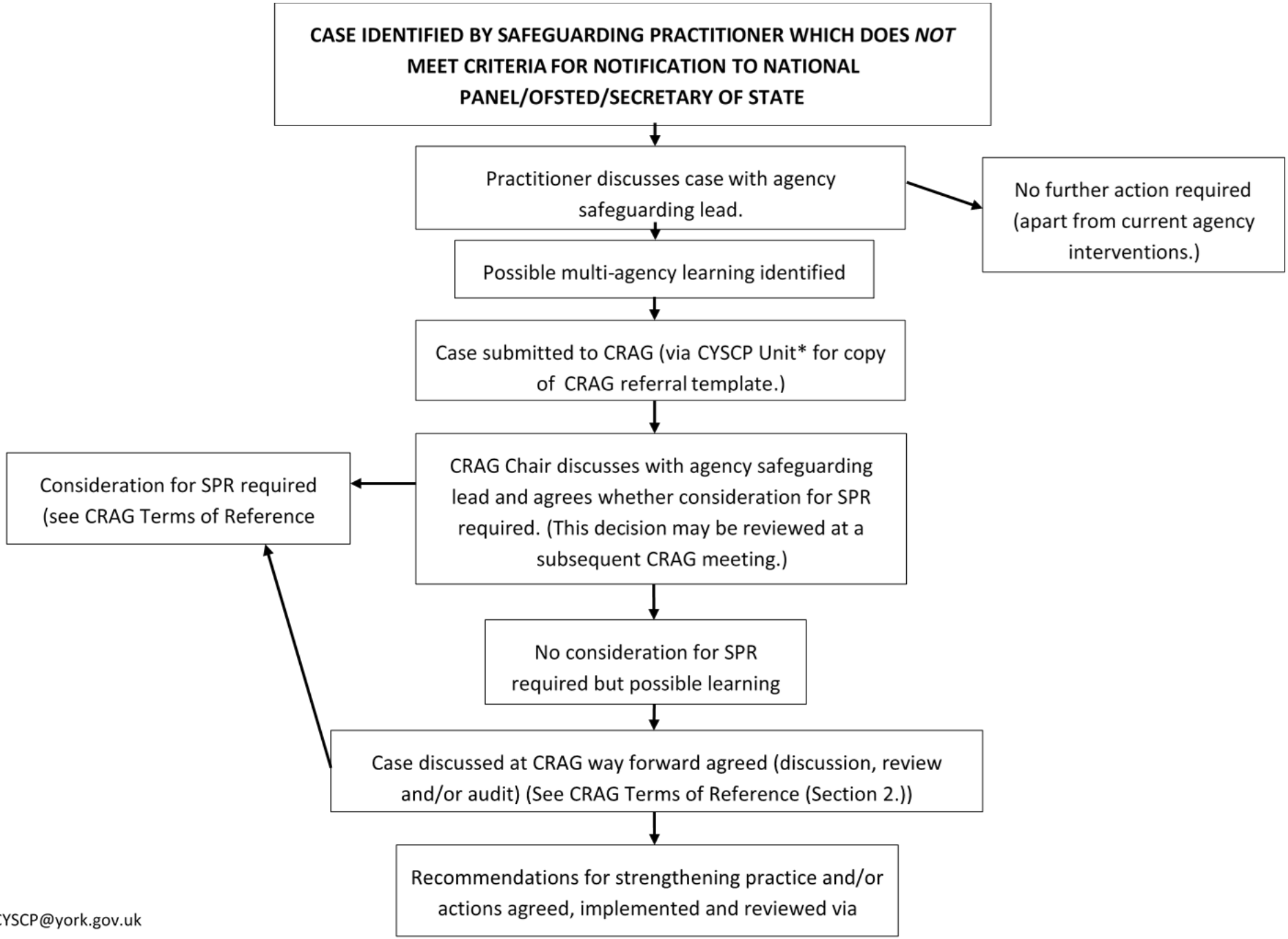
- Once decision has been made by the Executive to undertake a review (local safeguarding practice/multi-agency review/single agency review), the Executive will need to sign off the report with recommendations. The Case Review Sub-group will be responsible for ensuring any identified recommendations are completed.

Information Sharing

Effective sharing of information sharing is important when considering reviews Partner Agencies have worked together to develop a multi-agency overarching City of York and North Yorkshire Multi-Agency Information Sharing Protocol to create a positive culture of sharing information and facilitate more effective Data Sharing practices between Partner Agencies, with the aim of improving service delivery.

The Protocol applies to all information being shared by signatory Partner Agencies and it establishes the types of data Partner Agencies will share, how data is handled and the legislation which allows the information to be shared, as well as outlining processes for developing Partner Agency Information Sharing Arrangements.

The Department for Education has produced guidance on information sharing for people who provide safeguarding services to children, young people, parents and carers



*CYSCP@york.gov.uk

Form 1 - Consideration Request for Learning: Local Safeguarding Practice Review/Multi-Agency Case Review/Rapid Review or alternative methodology investigation

The City of York Safeguarding Children Partnership (CYSCP) is responsible, in accordance with Working Together to Safeguard Children (2018), to identify serious safeguarding cases which raise issues of importance to improve Child Protection and Safeguarding Practice within the City of York. The CYSCP Case Review Sub-Group (CRG) is responsible for having oversight and managing and reviewing cases to identify improvements to practice and safeguard children and promote the welfare of children.

The CRG includes representation from Local Authority Children Services and School Safeguarding, North Yorkshire Police, Vale of York Clinical Commissioning Group, York and Scarborough Teaching Hospital Foundation Trust, Tees, Esk and Wear Valleys Foundation Trust, Health Child Service, and is supported by the CYSCP Business Manager and CYSCP Business Unit.

This template is to be completed if you or your agency has identified a case where you feel multi-agency learning can be obtained and sharing lessons learned across the City of York. In addition, the CRG sub-group encourages good practice cases to share learning. Prior to submission of this form to the CYSCP Business Unit, you should discuss with your agencies safeguarding lead/representative who attends the CRG.

Please submit your completed form to cyscp@york.gov.uk

THE REFERRER SHOULD COMPLETE ALL OF THE FOLLOWING SECTIONS, PROVIDING AS MUCH INFORMATION AS POSSIBLE.

REFERRERS DETAILS

Referrer's Name	
Referrer's Job Title	
Referrer's Agency	
Referrer's Contact Details	
Date referrer submitted	
Name and contact details of safeguarding lead/representative/CYSCP Member who has authorised	

CHILD/YOUNG PERSON'S DETAILS

Child/Childrens Name(s)	Child/Children Date of Birth	Child Address	MOSAIC Number	NHS number	Ethnicity	Gender	Child Status*

*Child Status = Looked After Child (LAC), Child Protection Plan (CPP), Child in Need (CiN), Early Help (EH)

Mothers Name	Mothers Date of Birth	Mothers Address	Mosaic Number	NHS number	Ethnicity	Gender
Mothers Partners Name (if applicable)	**Mothers Partners Date of Birth**	**Mothers Partners Address**	**Mosaic Number**	**NHS number**	**Ethnicity**	**Gender**
Fathers Name	**Fathers Date of Birth**	**Fathers Address**	**Mosaic Number**	**NHS number**	**Ethnicity**	**Gender**

Fathers Partners Name (if appliciable)	Fathers Partners Date of Birth	Fathers Partners Address	Mosaic number	NHS number	Ethnicity	Gender

Details of extended family and connected people (the people important to the child)

Name	Relationship to Child	Date of Birth	Address	Mosaic number	NHS number	Ethnicity	Gender

Genogram of Family XXX

PRACTITIONER'S DETAILS INVOLVED WITH THE YOUNG PERSON/FAMILY:

Practitioner	Name	Email Address
Social Worker		
Practice/Team Manager		
Health Visitor		
School Nurse		
School		
Nursery		

Childminder		
GP		
CAMHS		
Targetted Intervention Support Worker		
Dentist		
Police		
Youth Justice		
Probation		
Commissioned Services • **Hand in Hand** • **PACE** • **IDAS** • **Changing Lives** **(Drug & Alcohol Service)**		
Housing		
Yor Sexual Health		

CASE SUMMARY & REASON FOR CONSIDERATION

Date of Incident/ Death:		**Childs Name:**	
Is this a 'notifiable incident'*. **If yes are you aware as to whether the local authority has made a notification to the National Panel?** ***Working Together**	**1.**		
What type of review do you think is required – LCSPR / Case Review /Alternative process?			

Please provide brief details of the incident. *If you are aware of any other parallel reviews that will be taking place please make reference to these and who is leading on them.*
Case context/background

Why do you think this case needs to be reviewed? i.e. a rationale
What do you feel are the key multi-agency themes/learning points?
What are your suggested Terms of Reference for this review? Please consider also timeframes.
What is the lived experience of the child? What is life like for the child/children?
What is the outcome you feel needs to be achieved?

Chronology of Key Significant Events, Actions and Outcomes

When you are completing this section please ensure that you start with the oldest information first and that when filling out the date section column please use format below i.e. 10/04/21

Date (dd/mm/yy)	Event / Issue	Outcome	Source of Information

N.B. FOR CYSCP ACTION:

Date form received in the CYSCP Business Unit	
Date Case Review Group Chair notified of request	
Date Case Review Sub-Group considering request	
Agreed outcome	
Date when CYSCP Business Unit shared outcome with referrer	

FORM 2 - REQUEST FOR AGENCY INFORMATION

FOR CONSIDERATION BY CASE REVIEW SUB-GROUP

The Children and Social Work Act 2017 identifies a requirement for Local Safeguarding Partners to make arrangements

(a) To identify serious safeguarding cases which raise issues of importance in relation to the area and…

(b) For those cases to be reviewed under the supervision of the safeguarding partners, where they consider it appropriate to identify any improvements that should be made by persons in the area to safeguard to safeguard and promote the welfare of children.

The City of York Safeguarding Children Partnership (CYSCP) is responsible, in accordance with Working Together to Safeguard Children (2023), to identify serious safeguarding cases which raise issues of importance to improve Child Protection and Safeguarding Practice within the City of York. The CYSCP Case Review Sub-Group (CRG) is responsible for having oversight and managing and reviewing cases to identify improvements to practice and safeguard children and promote the welfare of children.

The CRG includes representation from Local Authority Children Services and School Safeguarding, North Yorkshire Police, Vale of York Clinical Commissioning Group, York and Scarborough Teaching Hospital Foundation Trust, Tees, Esk and Wear Valleys Foundation Trust, Health Child Service, and is supported by the CYSCP Business Manager and CYSCP Business Unit.

In order to discuss cases which have been referred for consideration i.e. for a multi-agency review/single-agency review or rapid review, the CYSCP require partners to share information (in accordance with information sharing agreement) by completing this

template. It is important for partners to provide this as the information will be collated and form the basis for discussion at learning review meetings.

Please submit your completed form to cyscp@york.gov.uk

1. **Information submitted by:**

Full Name:	
Job Title:	
Agency:	
Email address:	

2. **Case Information (TO BE COMPLETED BY CYSCP BUSINESS UNIT):**

Agency who referred in:
Rationale for Discussion in Case Review Sub-Group:

Timeframe of concern (i.e period from and to):
Initial scope of review (i.e. Terms of Reference/Key Practice Episodes):

3. **Family Details (TO BE COMPLETED BY CYSCP BUSINESS UNIT):**

Please use full names for all members of the family

Child/Childrens Name(s)	Child/Children Date of Birth	Child Address	MOSAIC Number	NHS number	Ethnicity	Gender	Child Status*

Mothers Name	**Mother Date of Birth**	**Mothers Address**		**Mosaic Number**	**NHS number**	**Ethnicity**	**Gender**
Fathers Name	**Fathers Date of Birth**	**Fathers Address**		**Mosaic Number**	**NHS number**	**Ethnicity**	**Gender**
Mothers Partners Name (if appliciable)	**Mothers Partners Date of Birth**	**Mothers Partners Address**		**Mosaic Number**	**NHS number**	**Ethnicity**	**Gender**
Fathers Partners Name (if appliciable)	**Fathers Partners Date of Birth**	**Fathers Partners Address**		**Mosaic number**	**NHS number**	**Ethnicity**	**Gender**

***Child Status = Looked After Child (LAC), Child Protection Plan (CPP), Child in Need (CiN), Early Help (EH)**

Details of extended family and connected people (the people important to the child) - *Please use full names for all members of the family*

Name	Relationship to Child	Date of Birth	Address	Mosaic number	NHS number	Ethnicity	Gender

Genogram of Family – please use full names*

***To be completed by agency if possible and the agency has the information. If it is not possible the CYSCP Business Unit will endeavour to complete.**

Pen Picture of Family – please use full names **

**** Please provide if your agency is able to.**

4. **Agency involvement:**

Please provide brief details of any incidents with these children/family and your agency's involvement. ***If you are aware of any other parallel reviews that will be taking place please make reference to these and who is leading on them.***

5. Chronology

Chronology of Key Significant Events, Actions and Outcomes

Date (dd/mm/yy)	Event / Issue	Outcome	Family Member	Source of Information

6. Analysis

Analysis / Initial Observations from information gathered

7. **What is life like for this child/children/family?**

Can you give a brief outline of the lived experience of the young people in this family including unborn, pre-verbal and non-verbal/ Please include any relevant historical information i.e. what is life like for this child/children/family

8. **Learning**

Please identify any potential learning for your agency or for the multi-agency safeguarding partnership (CYSCP)

9. **Good Practice**

Please identify any good practice for your agency or for the multi-agency safeguarding partnership (CYSCP)

10. COVID-19

Please identify any potential learning for your agency from COVID-19

This case will be discussed at the meeting on (TBC) please ensure that you are fully briefed regarding information pertaining to this case to ensure that the Case Review Sub-Group is able to reach a decision regarding a potential review of this case.

City of York Safeguarding Children Partnership

Case Review Sub-Group (CRG)

FORM 3 - Rapid Review Template

Rapid reviews for the City of York Safeguarding Children Partnership (CYSCP) are undertaken by the CYSCP CRG. The CRG includes representation from Local Authority Children Services and School Safeguarding, North Yorkshire Police, Vale of York Clinical Commissioning Group, York and Scarborough Teaching Hospital Foundation Trust, Tees, Esk and Wear Valleys Foundation Trust, Health Child Service, and is supported by the CYSCP Business Manager and CYSCP Business Unit.

This template is to be completed for each case referred to the CYSCP Case Review Subgroup for consideration for Local Child Safeguarding Practice Reviews (LCSPR), including all cases where a notification about a serious child safeguarding case has been made to the National Child Safeguarding Panel in accordance with Working Together 2023.

1. **Referral completed by:**

Full Name:	
Job Title:	
Agency:	

Email address:	
Date referral submitted:	

2. **Chair of Rapid Review:**

Full Name:	
Job Title:	
Agency:	
Email address:	

3. **Agencies invited and present at the Rapid Review Meeting**

Full Name	Job Title	Organisation	Email contact

4. **Agencies invited but not present at the Rapid Review Meeting**

Full Name	Job Title	Organisation	Email contact

5. **Child/Children's Details:**

Child/Childrens Name(s) – please complete full name	Child/Children Date of Birth	Child Address	MOSAIC Number	NHS number	Ethnicity	Gender	Child Status*

***Child Status = Looked After Child (LAC), Child Protection Plan (CPP), Child in Need (CiN), Early Help (EH), any identified additional needs i.e. Disability, SEND**

6. Family Details

Please use full names for all members of the family

Mothers Name	**Mothers Date of Birth**	**Mothers Address**	**Mosaic Number**	**NHS number**	**Ethnicity**	**Gender**
Fathers Name	**Fathers Date of Birth**	**Fathers Address**	**Mosaic Number**	**NHS number**	**Ethnicity**	**Gender**
Mothers Partners Name (if applicable)	**Mothers Partners Date of Birth**	**Mothers Partners Address**	**Mosaic Number**	**NHS number**	**Ethnicity**	**Gender**
Fathers Partners Name (if appliciable)	**Fathers Partners Date of Birth**	**Fathers Partners Address**	**Mosaic number**	**NHS number**	**Ethnicity**	**Gender**

7. Main Carer Details if Child is Looked After

Full Name of Main Carer	
Date of Birth	
Parental Responsibility (Yes or No)	
Caring Arrangement e.g. Private Fostering	
Date caring responsibility started	

8. **Details of extended family and connected people (the people important to the child) -** ***Please use full names for all members of the family***

Name	Relationship to Child	Date of Birth	Address	Mosaic number	NHS number	Ethnicity	Gender

Genogram of Family – Please use full names

Pen Picture of Family – Please provide even though you may have limited information **Please use full names**

9. Incident Details

Date of Death or Serious Incident	
Location of Incident	

10. Practitioner's details involved with the young person/family:

Practitioner	Full Name	Email Address
Social Worker		
Targetted Intervention Support Worker		
Practice/Team Manager		
Health Visitor		
School Nurse		
School		
Nursery		
Childminder		
College		
GP Name		

GP Practice Name		
CAMHS		
Dentist		
Police		
Youth Justice		
Probation		
Commissioned Services • **Hand in Hand** • **PACE** • **IDAS** • **Changing Lives (Drug & Alcohol Service)**		
Housing		
Yor Sexual Health		
Ambulance Service		
Other		

11. Characteristics of the Case

Domestic Abuse	☐	**Substance Abuse**	☐	**Peer on peer Abuse**	☐
Parental mental health	☐	**Child's Mental Health**	☐	**Non-accidental head injury**	☐
Sexual abuse	☐	**Parent in care**	☐	**Parent is care leaver**	☐
More than one child abused	☐	**Child of teenage pregnancy**	☐	**Serious illness**	☐
Emotional abuse	☐	**Recent neglect**	☐	**Long standing neglect**	☐
Physical abuse	☐	**Exploitation**	☐	**Non Accidental Injury**	☐
Contextual safeguarding	☐	**Perplexing Presentations/Fabricated Illness**	☐	**Learning disabilities**	☐
Looked After Child	☐	**Allegations against Professionals (LADO)**	☐		

12. Reason for consideration

Is abuse or neglect known or suspected?	**Yes** ☐	**No** ☐
Has the child died or been seriously harmed?	**Yes** ☐	**No** ☐

13. Case Summary

This should include facts about the case and reasons why the case was notified/ referred.

Highlight any information which might trigger a review.

Please reference documents which informed the summary e.g. chronologies, strategy meeting minutes, SuDIC minutes etc.)

This should also be concise but sufficient to understand the context for the learning and recommendations;

- ***a summary of why relevant decisions by professionals were taken;***
- ***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; and,***
- ***what needs to happen to ensure that agencies learn from this case.***

Timescales for Review (i.e. how far back should professionals review their files)	
Rationale for Review	
Key Practice Episodes	
Learning	

Recommendations	

14. **Has a case with similar/identical themes been reviewed locally within the last 3 years?**

Yes ☐ **No** ☐

15. **Immediate Action – Where necessary what action has been taken to ensure the child is safeguarded?**

16. **Immediate and Potential Learning and Improvement – Would a review of this case likely identify learning to impove arrangements to safeguarding and promote the welfare of children? What learning might we see? Are there already visible lessons to learn?**

17. Are there other learning processes being undertaken by agencies? Serious incident etc.

18. Recommendations for Level of Review

i National Safeguarding Practice Review **a child suffers a serious injury or death and abuse or neglect is known or suspected, and**	
the case highlights or may highlight on a national level improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified	☐
the case raises or may raise issues requiring legislative change or changes to guidance issued under or further to any enactment	☐
the case highlights or may highlight recurrent themes on a national level in the safeguarding and promotion of the welfare of children	☐

ii Local Safeguarding Practice Review **a child suffers a serious injury or death and abuse or neglect is known or suspected, and**

the case highlights or may highlight improvements needed on a local level to safeguard and promote the welfare of children, including where those improvements have been previously identified	☐
the case highlights or may highlight recurrent themes on a local level in the safeguarding and promotion of the welfare of children	☐
the case highlights or may highlight concerns regarding two or more agencies working together effectively to safeguard and promote the welfare of children	☐
the case has been considered by the Child Safeguarding Practice Review Panel and they have concluded that a local review may be more appropriate	☐

iii No Review Required but any local learning will be identified	
None of the criteria in i or ii above met but learning locally will be taken forward in the Case Review Subgroup	☐

19. Recommendation made by three Statutory Partners

Recommendation	
Date case discussed with three statutory partners	
Statutory Partner recommendation	

20. Recommendation to the National Child Safeguarding Practice Review Panel

After reviewing the information for this case the recommendation from the LSCP/Safeguarding partners is:

a. for a National Safeguarding Practice Review to be Undertaken ☐

b. for a Local Safeguarding Practice Review to be Undertaken ☐

c. no review required but any local learning will be identified ☐

Signed _____

Name _____

Position _____

Date _____