City of York Children's Safeguarding Partnership

Case Review Practice Guidance

Who is the Guidance for?

This practice guidance should be adhered to by all partner agencies of the City of York 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.

This practice guidance should be read alongside the relevant statutory guidance set out in Working Together 2026 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 Local Child Safeguarding Practice Reviews must be concluded prior to consideration or conclusion at the Child Death Overview Panel.

The functions of the Case Review Subgroup

The Case Review Subgroup, in accordance with Working Together to Safeguard Children (2026) 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 City of York Safeguarding Children Partnership 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 (2026) 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, 2026 Chapter 5 page 136).

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, 2026).

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.

City of York Safeguarding Children Partnership

Local Procedure for Rapid Reviews

CRITERIA FOR SERIOUS SAFEGUARDING REVIEW (CHAPTER 5 WORKING TOGETHER 2026 pp 134)

16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) states:

Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if:

(a) the child dies or is seriously harmed in the local authority's area

(b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England

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*

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 City of York Safeguarding Children Partnership: 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 care leaver or care experienced young person has died, whether or not abuse or neglect is known or suspected. Further information in relation to the this is on the Partnership website.

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 (2026) 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 Partnership 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.

Upon receipt of a notification for a Rapid Review, a Chair for the Rapid Review needs to be identified. All members of the Case Review Sub-Group have an expectation to Chair Rapid and Learning Reviews and there is a rota to ensure that all agencies take a share of the Chairing.

The Chairing of the Rapid Review however will depend on the concerns from the Rapid Review and therefore which agency is felt best placed to Chair.

A Form 2 will be circulated by the Partnership 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 Partnership 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 Partnership Business Manager, Chair of the Case Review Sub-Group 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 rapid 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 and culture
- 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 (2026);
    - 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 a Local Child Safeguarding Practice Review? If it is decided to proceed with a Local Child Safeguarding Practice Review, 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 Local Child Safeguarding Practice Review recommended?
- Following the Rapid Review meeting it is the responsibility of the Rapid Review Chair with support from the Partnership Business Unit Manager to write a Report using the Form 3 template. They are responsible for meeting with the three statutory partners to present the outcome of the Rapid Review and the recommendation made by the Rapid Review Panel Members. The Independent Scrutineer will attend this meeting to support where possible.

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 a Local Child Safeguarding Practice Review 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 (2026) does not mean there is an automatic expectation to carry out a Local Child Safeguarding Practice Review.

Safeguarding partners need to be clear from the outset what the benefit would be of conducting a Local Child Safeguarding Practice Review following on from a quality rapid review. Rapid reviews should always set out a very clear rationale for doing a Local Child Safeguarding Practice Review. The three statutory partners should be explicit about the key lines of enquiry that the Local Child Safeguarding Practice Review would seek to consider.

Good practice Local Child Safeguarding Practice Review's identify new learning that is not yet available in local safeguarding systems, or they tackle perennial problems that need further or perhaps different attention.

A Local Child Safeguarding Practice Review does not automatically explore learning from a rapid review in more detail although partners may decide to initiate a Local Child Safeguarding Practice Review 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 a Local Child Safeguarding Practice Review 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 a Local Child Safeguarding Practice Review 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 a Local Child Safeguarding Practice Review if it feels that the Rapid Review has not adequately explored the learning or if there may be further learning to be gained from a Local Child Safeguarding Practice Review.

Informing the National Panel of Decision

As soon as the Rapid Review is complete, the Partnership Business Unit 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 Partnership Business Unit 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 Child 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 Working Together 2026

- 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, 2026).

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 Sub-Group member should then submit a Form 1 to the Partnership 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 criteria 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 Partnership 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.

Professionals Resolutions process

Professional concerns and disputes may arise at any stage.

If professional disagreements remain unresolved, please refer to the Partnership Professionals Resolutions Practice Guidance.

The Partnership 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.

Partnership Monitoring, Learning and Impact

The Case Review Subgroup is responsible for ensuring that any actions, learning points or recommendations are progressed. All Case Review Subgroup Members are responsible for ensuring that actions are completed by their individual agency and reporting back on the impact on practice following the Rapid Review/ Local Child Safeguarding Practice Review.

Case Review sub-group members are responsible for disseminating all learning from all cases within their own organisation and across the Partnership. This includes any national or regional learning.

Learning can be disseminated as follows:

- City of York Safeguarding Children Partnership Learning Masterclass briefing sessions
- One Minute Guide's
- 7 point briefings
- Updates to Policies and Procedures
- Updates on the website

- Training Sessions
- Newsletter

Process

If the Partnership commission a review the City of York Safeguarding Children Partnership 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
- 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

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

Submission of cases for consideration

If you feel you have a case that should be considered for discussion at Case Review Sub-Group please email cyscp@york.gov.uk.