NW Statutory Practice Review Framework and Approach Briefing

19th March 2026

North West Children's Safeguarding Partnership

Department for Education

Vulnerability Knowledge & Practice Programme

NHS

North West ADCS Leading Children's Services

North West Regional Improvement Plan Pilot

Agenda:

Time	Item	Objective/ Outcome
10am	Welcome and Overview	• Purpose of the session • Anticipated Outcomes • Overview of Serious Child Safeguarding Cases criteria and Decision Making • Key stages of learning from serious cases
10.10am	Practice Review Process- National Insights	• Best practice approaches • Regional learning from the National Panel • Recurrent themes
10.30am	NW Practice Review Framework	• Introduction to the NW Framework and guidance • Focus on system learning and improvement • Promoting consistency, governance, and statutory clarity • Introduce the shared tools and resources
10.40am	Best Practice: Rapid Reviews	• Statutory Rapid Review process • Key requirements and effective chairing
11am	Best Practice: Child Safeguarding Practice Reviews (CSPR)	• CSPR process and expectations • Commissioning reviewers, KLOEs, publication, media, and governance
11.20am	Practice Review Methodologies & Embedding Learning	• Overview of systems learning approaches and assumptions • Levels of systems analysis • Strengths of systems analysis • Expected Outcomes
11.30am	System Insights: Reflection	• Next Steps
12noon	Close	

Purpose of the Session:

- Introduce the NW Practice Review Framework and Approach
- Share Best Practice in conducting Rapid Reviews and CSPR's
- Promote regional consistency in applying statutory processes
- Support and Enable System Wide Reflection/ Self Assessment
- Highlight systems review methodologies and best practice in embedding learning from practice reviews.

Anticipated Outcomes:

- Identify and apply best practice principles in conducting reviews
- Demonstrate increased confidence in applying statutory processes
- Contribute to continuous learning and improvement across the region.

North West Children's Safeguarding Partnership

Department for Education

North West ADCS Leading Children's Services

North West Regional Improvement Plan Pilot

Serious Child Safeguarding Cases

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

Serious child safeguarding cases are those in which:

- Abuse or neglect of a child is known or suspected
- The child has died or been seriously harmed.

Safeguarding partners **must**:

- Identify and review serious child safeguarding cases which, in their opinion, raise issues of importance in relation to their local area
- Commission and oversee the review of those cases if they consider it appropriate.



Decision Making around Serious Child Safeguarding Cases

- The Local Authority must notify the National Panel of all qualifying serious incidents via the Child Safeguarding Online Notification System **within five working days.**
- While the Local Authority holds responsibility, good practice is for all safeguarding partners to agree on notifications, using local dispute resolution processes if disagreements arise.
- The LSCP Business Unit should support the screening process and record partnership discussions with a clear, evidence-based rationale for decisions.
- Lead safeguarding partners are **ultimately accountable** for ensuring that learning from serious child safeguarding incidents is implemented, even if decision making locally is delegated- how do they know?

Referral/ Screening Process

Professional identifies a case that they believe meets the criteria for a serious child safeguarding case- referral to be made to the LSCP **as soon as possible**.

Upon receipt of a referral to the Local Safeguarding Children Partnership, the statutory partners should convene **within 48hours** to discuss the circumstances and to agree next steps.

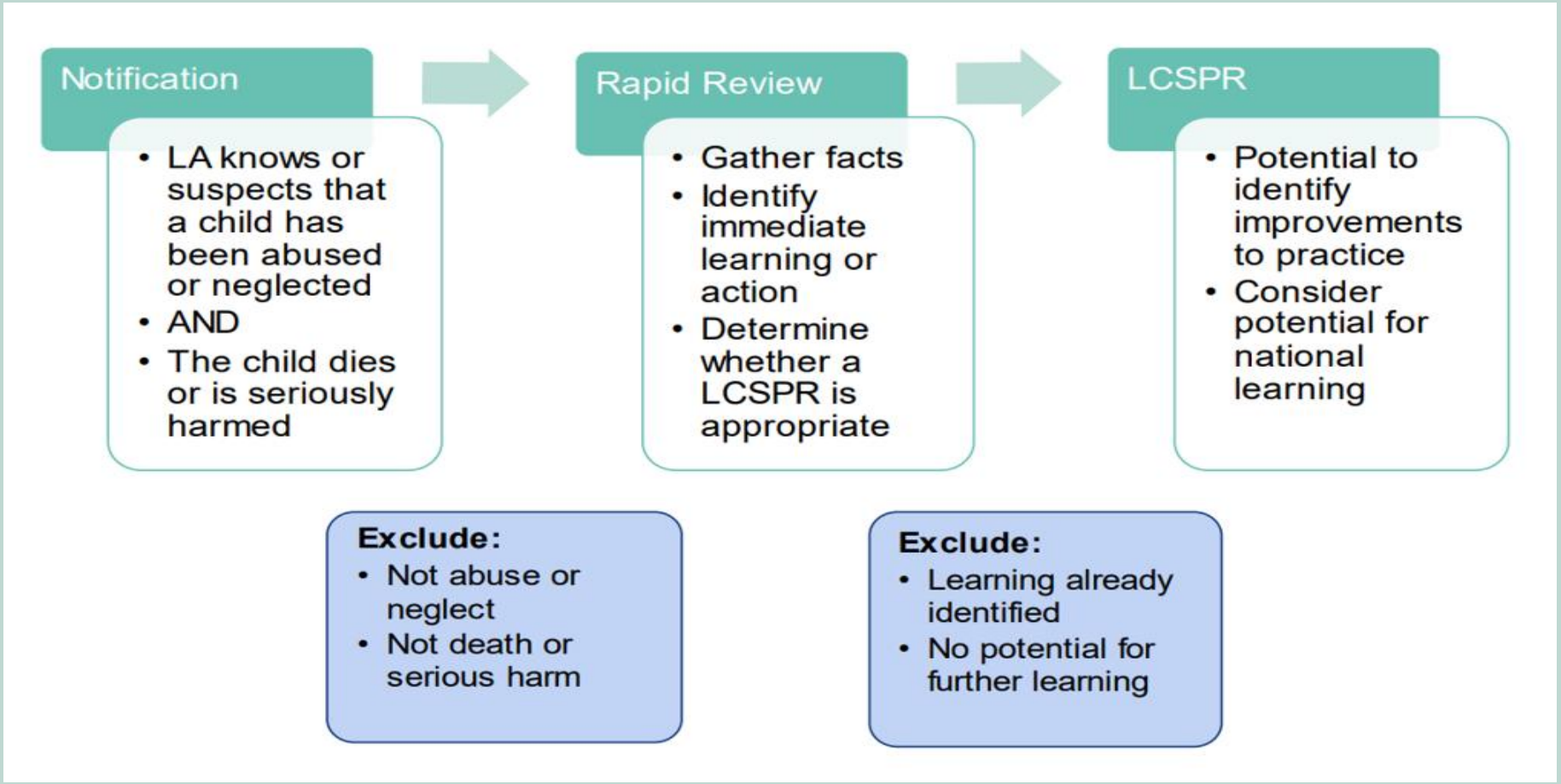
If the Outcome of the Screening process is that the criteria are met, a Serious Incident Notification should be made by the Local Authority **(within 5 working days).**

If screening finds the criteria are not met, no notification is required. Partners should agree whether learning could be gained, consider a non-statutory Practice Review where relevant, and inform the referrer of the rationale if no further action is taken.

Screening Panel outcomes should be shared with the Independent Scrutineer for oversight and ratification of decision making.



Key Stages of Learning from Serious Cases



Things to Consider:

Workforce Awareness and Understanding:

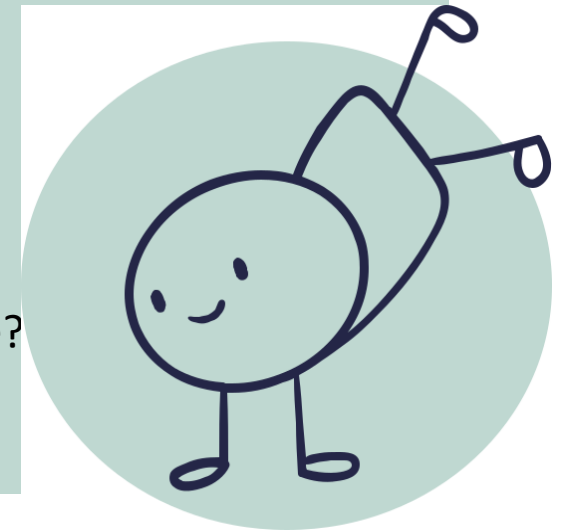
- How assured are we that our multi-agency workforce understands the criteria for initiating a practice review?
- How well do practitioners understand the process for referring concerns to the LSCP?

Referral and Initial Response Process:

- Does our MASA have clearly defined, accessible processes for receiving and managing referrals relating to potential serious child safeguarding incidents?
- How confident are we that these processes are applied consistently across partner agencies?
- Are there any barriers that may prevent timely or appropriate referrals?

Screening, Decision- Making and Timeliness:

- Do we have a robust screening process or panel in place to review referrals and SINs?
- Are delegated leads clearly identified, appropriately trained, and empowered to make timely and proportionate decisions?
- How do we assure ourselves that decision-making is transparent, consistent, and defensible?



Things to Consider:

Communication and Information Sharing:

- Where decision-making around reviews is delegated locally, how are DSPs/LSPs kept informed about Serious Incident Notifications and ongoing review activity?
- How do we ensure information sharing supports learning and early safeguarding improvement?

Partnership Working and Collective Responsibility:

- To what extent do safeguarding partners operate as a unified team rather than representing individual agency perspectives?
- How do we actively promote shared ownership and accountability for safeguarding outcomes?
- What opportunities exist to strengthen collaborative decision-making and challenge?

Governance and Oversight:

- How effective are current governance arrangements in providing oversight, scrutiny, and assurance of SIN responses?
- Where could governance structures be strengthened to improve clarity, accountability, or escalation processes?
- How does the Independent Scrutineer review and challenge decision-making, and how is this feedback used to improve practice?

Things to Consider:

Infrastructure and Business Unit Support:

- Is the Business Unit infrastructure sufficient to effectively support SIN processes, including coordination, recording, and tracking actions?
- Are staffing, systems, and resources proportionate to the demands of the process?

Learning, Culture, Language and Recording:

- Do our discussions, reports, and documentation demonstrate a clear focus on learning and improvement rather than blame?
- How do we ensure that language used across MASA activity supports openness and professional curiosity?
- Are decisions, rationales, and next steps clearly recorded, stored, and accessible through Business Unit systems?
- How effectively is learning from incidents shared across the partnership and translated into practice improvement?



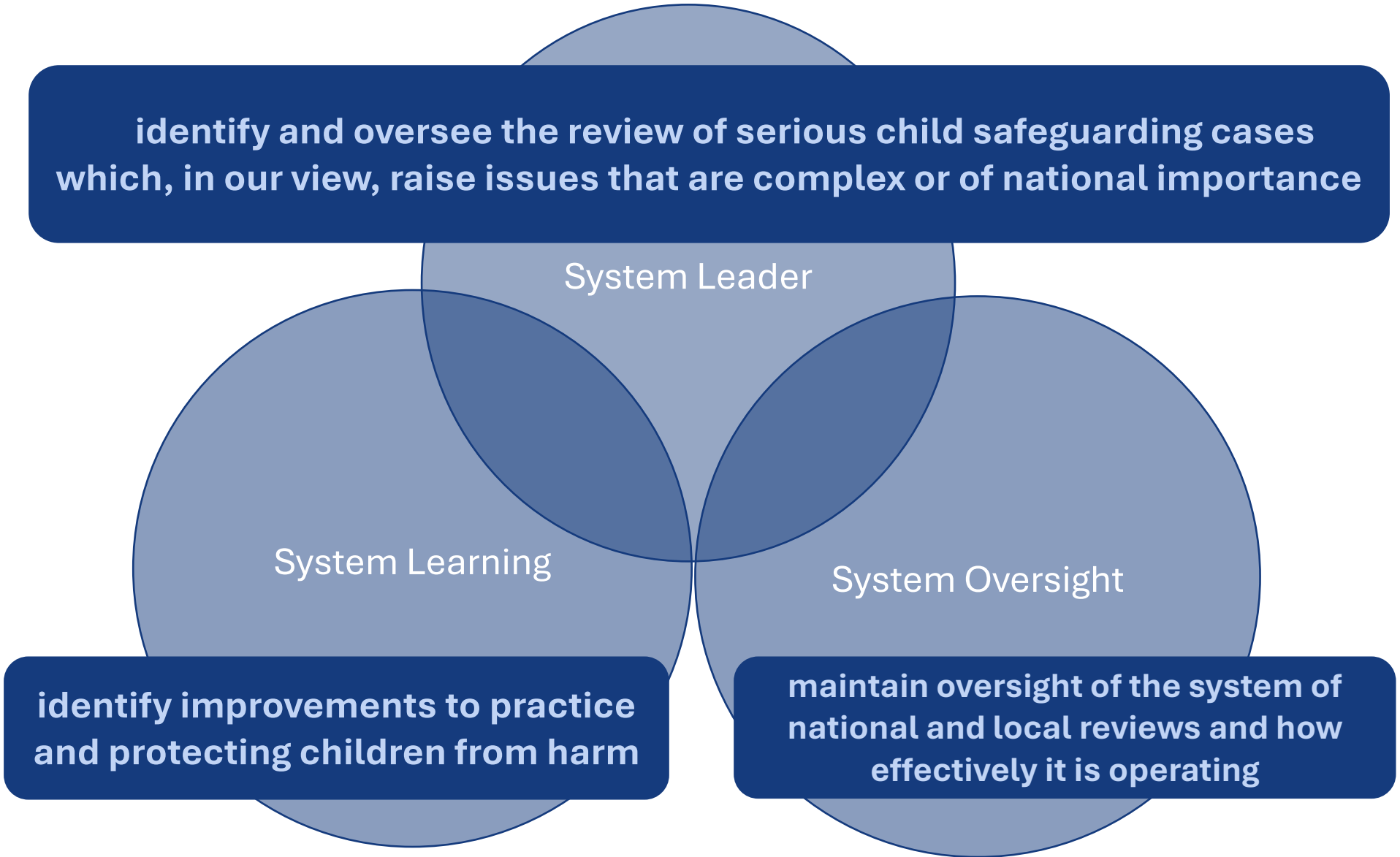
THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

What's good practice for notifying and reviewing serious child safeguarding incidents?

Jenny Coles- Child Safeguarding Practice Review Panel Member

About the Panel: Statutory and independent
What is an "expert committee"?

identify and oversee the review of serious child safeguarding cases which, in our view, raise issues that are complex or of national importance



identify improvements to practice and protecting children from harm

maintain oversight of the system of national and local reviews and how effectively it is operating

Introduction

- **Panel published updated guidance in June 2025** to support safeguarding partners in protecting and promoting the welfare of children.

- **Working Together 2023 alignment** - The guidance complements Working Together to Safeguard Children 2023, offering practical support to help safeguarding partners meet their statutory responsibilities effectively.

- **Targeted relevance & system wide use**- The guidance is particularly relevant for those involved in serious incident notifications, rapid reviews, and LCSPRs. All safeguarding organisations including local authorities, police, education and childcare settings are encouraged to use the guidance as a practical tool

- **Ongoing guidance development**
  The Panel welcomes ongoing feedback and will continue to update the guidance in response to sector learning, legislative changes, and the development of the Child Protection Authority.

Serious Incident Notifications

- Learning from serious incidents is vital and is the first stage in understanding why a child has died or been seriously harmed.

- At this stage, notifications may contain limited information, but it is essential that the data provided is accurate and reflects what is known at the time as it used for national trend analysis.

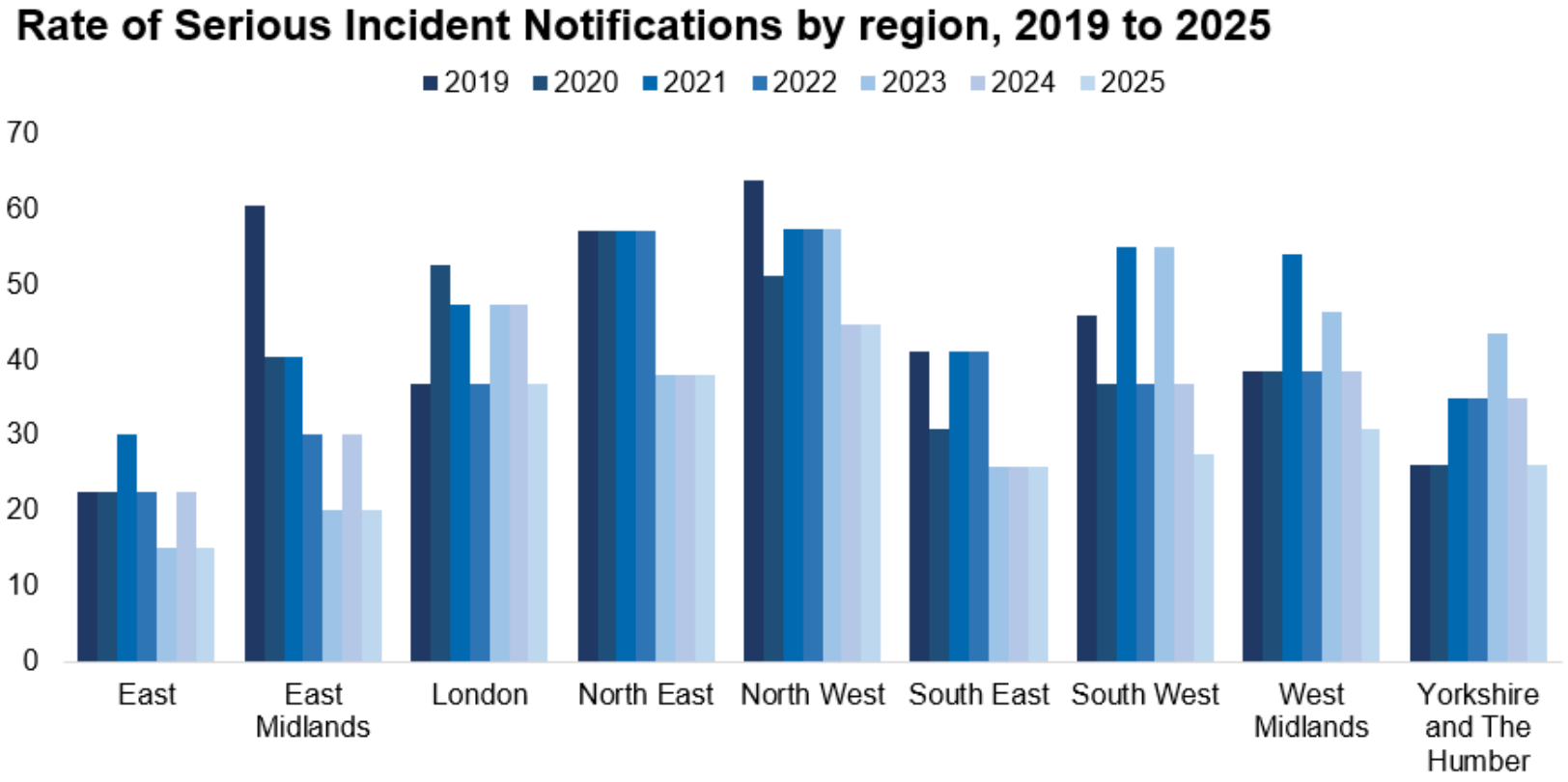
- As a reminder when completing a notification:

  - Be specific about all linked children and adults.
  - Provide information of what is known (an overview, but not explicit detail).
  - The notification should include what actions have been taken to safeguard all children linked to the incident. This should include actions taken by safeguarding partners to manage and reduce risk from the perpetrator.
  - Be clear on what is known and what is suspected, in particular, where abuse or neglect is suspected.

Serious Incident Notifications

- **Notifications fell for the second consecutive year to the lowest level since the statutory duty to notify the Panel came into effect; notifications relating to child death and serious harm also fell to the lowest level since 2019**

- **There are differences in regional reporting of SINs. Local Authorities in the North-West tend to submit a higher rate of SINs. However, contextual information is important. Deprivation and local practices are likely to drive these regional differences in reporting.**



Why do we notify?

- ✓ **Purpose of Notifications** - Notifications are the starting point for identifying serious child safeguarding cases. They help surface critical learning and prompt reviews that aim to improve safeguarding practice and promote the welfare of children.
- ✓ **Systemic Learning and Improvement** - Reviews aim to uncover systemic issues and inform changes in policy and practice. This supports a dynamic, self-improving safeguarding system.
- ✓ **Shared Responsibility for Learning** - Learning from serious incidents is a shared responsibility: locally by safeguarding partners, and nationally by the Child Safeguarding Practice Review Panel.
- ✓ **Contextual and Reflective Decision-Making** - Notification decisions rely on professional judgement, considering unique case contexts. Reflective approaches strengthen safeguarding responses.
- ✓ **Challenges in Thresholds -** Safeguarding partnerships often face pressures and uncertainty when interpreting notification thresholds, which can impact consistency and confidence. Clear rationale and collaborative reflection help support better decision-making.

KEY CHANGES IN THE GUIDANCE

Alignment with WT23	• Equal responsibilities for safeguarding partners, delegated roles, and stronger links with education and early years
Clarified areas of ambiguity	• The guidance clarifies previously ambiguous areas like serious harm, drawing on national evidence to support more consistent, reflective decision-making
Inclusion of Race and Ethnicity considerations	• The guidance includes new content to support complex cases, with a focus on race and ethnicity, clearer advice, practical examples, and stronger links to related review processes
Expanded guidance on specific circumstances	• Provides clearer advice on complex cases, including over-18s, non-recent abuse, and serious youth violence
Practice-focused additions	• The guidance highlights overlaps with CDOP, DHR, and IOPC to promote coordination among safeguarding processes

Effective Rapid Reviews

Clear Rationale for Notification	• Effective Rapid Reviews begin with a clear reason for notification to ensure relevance and focus
Timely and Structured Process	• A well-structured process completed in a timely manner is essential for effective Rapid Reviews
Focused Lines of enquiry	• Concentrated and relevant lines of enquiry help generate meaningful insights from the review
Multi-Agency Collaboration	• Strong collaboration across multiple agencies enhances the quality and applicability of reviews

Effective LCSPRs

In depth analysis	• Strong LCSPRs feature thorough analysis identifying root causes and systemic issues beyond surface details
Actionable learning points leadership oversight	• Clear, practical learning points guide safeguarding improvements, with leadership sign-off ensuring accountability and system-wide implementation
Engagement with Families and Practitioners	• Involving families, practitioners, and the child's voice ensures diverse perspectives and grounds the review in lived experience
Driving Systemic Improvement	• LCSPRs go beyond compliance to inspire systemic changes that enhance child safeguarding practices
Diversity and Equity	• Considers race, ethnicity, and other factors to ensure inclusive and reflective practice

Common themes on quality

Child's voice & lived experience

Race, ethnicity & culture

Depth of analysis

Understanding multi agency chronology and linking to analysis

Multi agency learning informing action plans and governance

Q&A

Thank You

Communications:

You can sign up to the mailing list online to receive Panel newsletters: http://eepurl.com/g6z_Tf

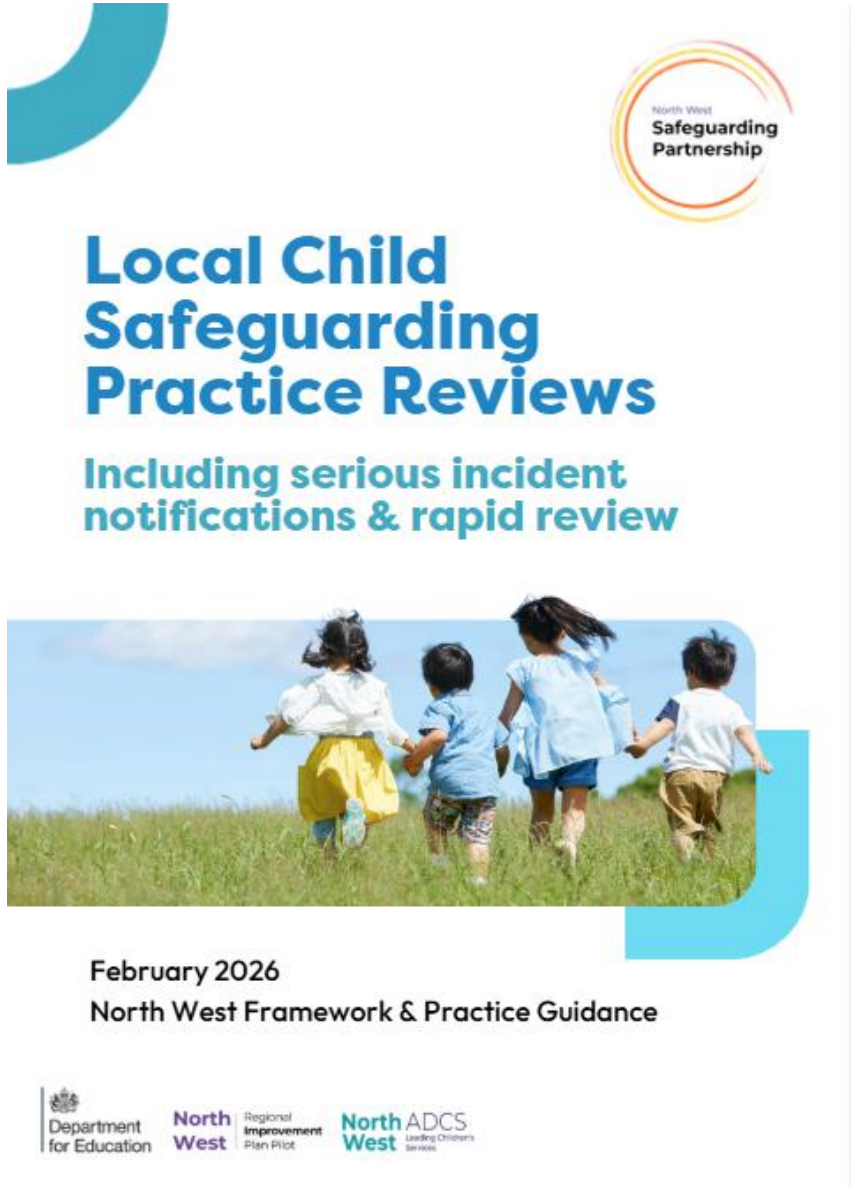
Follow us on LinkedIn: LinkedIn

Join our YouTube Channel: Child Safeguarding Practice Review Panel - YouTube

Email: Mailbox.NationalReviewPanel@education.gov.uk

NW Practice Review Framework & Approach

- Aims to strengthen **consistency, quality and impact**
- Supports NW MASAs in **decision- making** on Serious Incident Notifications (SINs)
- Describes **approach, order of events and expected timescales** for statutory practice reviews and provides **tools and templates** to support local processes
- Promotes a **systems-based approach** to learning
- Aligned with the **NW Safeguarding Effectiveness Framework**
- Draws upon research from the **National Child Safeguarding Practice Review Panel**



NW Practice Review Framework & Approach

System Learning and Improvement

- Each MASA should have established processes in place to review serious child safeguarding incidents
- Effective Governance arrangements and clear accountability are important
- MASAs are expected to establish a culture of learning and reflection focussed on continuous improvement

All reviews should:

- **Prevent Reoccurrence**: identify improvements to practice and wider systems to reduce the risk of similar incidents.
- **Focus on System, Not Blame**: Understand *why* incidents occurred across the whole system of help, support and protection, rather than holding individuals to account
- **Drive Change**: recommendations should lead to actual changes in practice
- **Promote Inclusivity** be child centred, inclusive and sensitive to factors like race, Ethnicity and socio-economic circumstances.



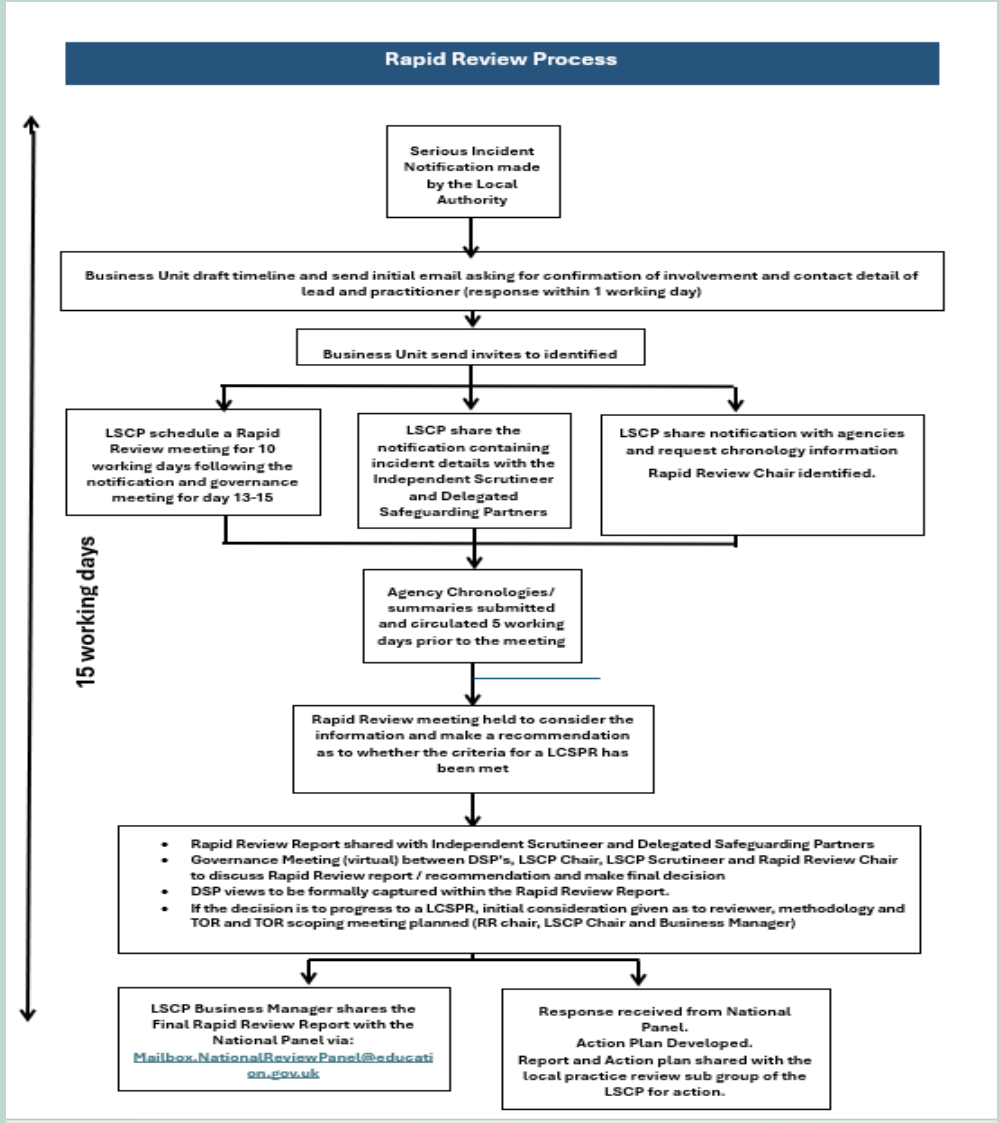
Rapid Reviews

- Safeguarding partners must complete a Rapid Review for all notified serious incidents
- A Rapid Review is a multi- agency process to quickly gather facts, consider immediate actions, and identify improvements
- It determines whether a Local Safeguarding Child Practice Review (LSCPR) is required (Working Together to Safeguard Children, 2023)
- If an LSCPR is commissioned, key lines of enquiry and review questions must be identified
- Partnerships should clearly outline learning, dissemination and actions within the report and action plan
- Decision must be shared with the National Panel within 15 working days
- Report should be reviewed by the Independent Scrutineer and signed off by the Delegated Safeguarding Partners before submission.



Rapid Review Process

- **Notification:** LA should notify the National Panel within 5 days of becoming aware of the serious incident
- **Information Sharing:** Partner agencies should provide information about their involvement with the child/ family
- **Review Meeting:** Convene to discuss the facts, identify immediate actions and highlight good practice or areas for improvement
- **Decide next steps:** Determine if a LCSPR is needed based on whether the case reveals learning about local systems
- **Submit Outcome:** Send the Rapid Review report to the National Panel within the 15- day deadline



Rapid Review Key Principles and Best Practice

Timeliness and Scope: Rapidly review cases where a child has been seriously harmed or abused, focusing on immediate action and initial analysis of ***why*** events occurred.

Multi-Agency Engagement: Involve all relevant agencies (police, health, social care) to gather a comprehensive, shared understanding of the facts, including a chronology of key events.

Systems Approach: Move beyond individual failings to analyse how organisational systems and multi-agency processes functioned, identifying prompt improvements to safeguard children.

Focus on Learning: Identify immediate learning points to disseminate, aiming to prevent recurrence before a full review is completed.

Decision-Making Criteria: Use the 15-day review to decide if a Local Child Safeguarding Practice Review (LCSPR) is necessary, considering if the case is complex or of national importance.

Child-Centred Perspective: Ensure the review reflects the child's perspective and context, including the impact of inequalities.

Immediate Action: Establish if any immediate, interim actions are needed to protect children

Reporting: Submit findings to the National Panel within 15 working days.



Things to Consider:

Strengthening Multi Agency Practice and Collaboration:

- Do your rapid reviews focus on why things happened, not just what happened, to improve future responses and identify systematic issues?
- Do you reflect on how agencies worked together?
- Do you ensure that all partners are engaged promptly in the Rapid Review process to gain a full picture?

Ensuring a Child Centred Focus:

- Reflect on whether reviews truly capture the child's lived experience rather than focussing solely on adult behaviours and professional actions.
- Analyse lived experience and consider how the child's day to day life was impacted and whether their voice was sought and heard.
- Focus on family context and background- including the role of fathers and partners who are often neglected in safeguarding assessments.

Maximising Learning from the Process:

- Are Rapid Reviews identifying immediate safety actions or merely summarising events?
- Identify Good Practice- don't just focus on failures. Replicate successful, strengths-based practice across the system.
- Use local and national evidence to check for recurrent themes



Local Child Safeguarding Practice Reviews (LCSPR)

Purpose: To explore how safeguarding practice can be improved through system changes.

A Serious Incident Notification does not automatically require a LCSPR.

Safeguarding partners must consider whether the case:

- Identifies improvements needed to safeguard and promote children's welfare
- Highlights recurring safeguarding themes
- Raises concerns about multi- agency effectiveness
- Has been considered by the National Panel as suitable for local review



Local Child Safeguarding Practice Review Process

- **Notification:** LA should notify the National Panel within 5 days of becoming aware of the serious incident

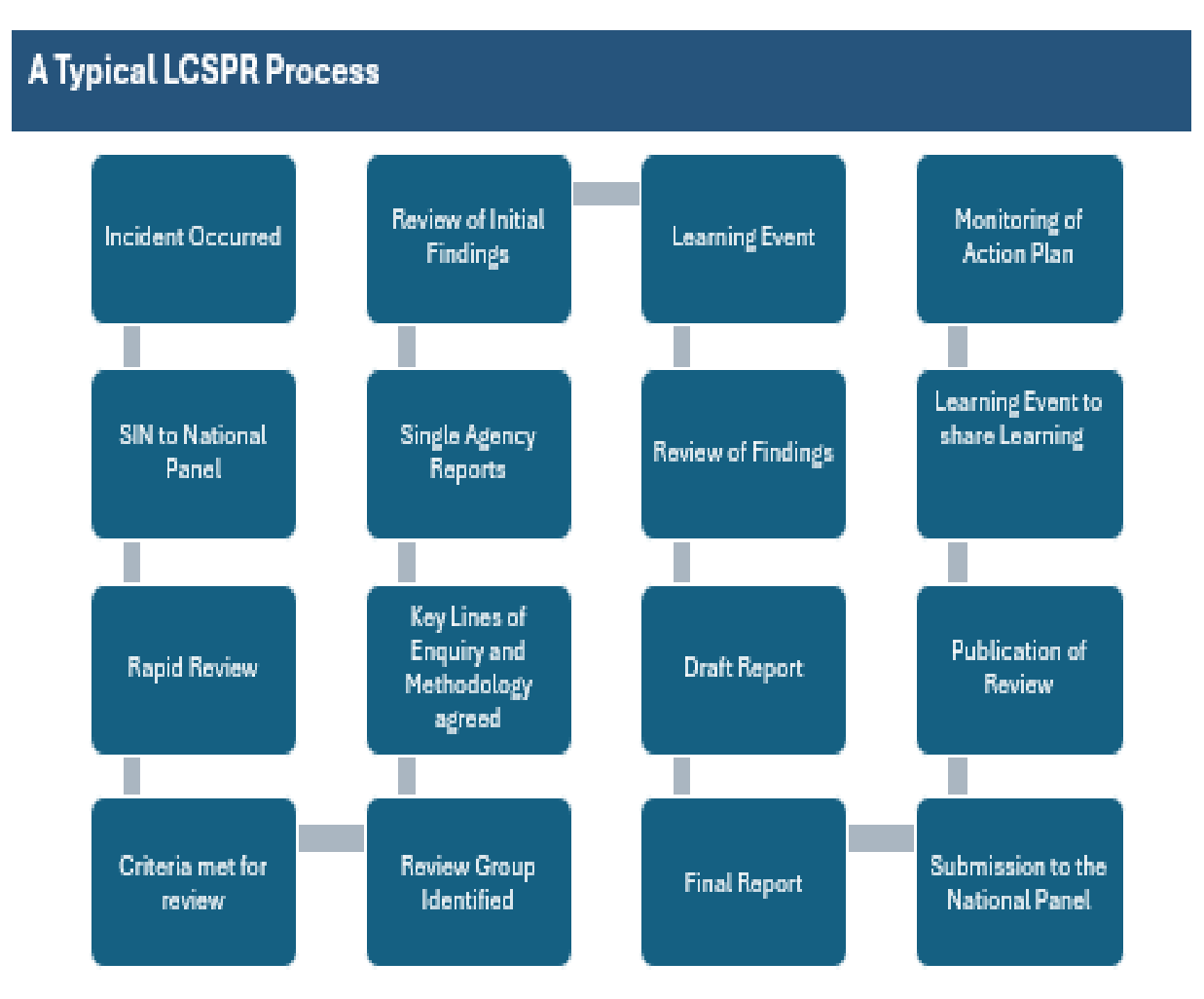
- **Rapid Review:** completed within 15 working days to identify immediate actions and decision to progress to LCSPR

- **Commissioning the Review:** Partners must appoint an Independent Reviewer.

- **Conducting the Review:** focus on how organisations worked together. It must include

- Perspectives from the child (where possible) and their family
- Engagement with frontline practitioners and managers
- A focus on systemic issues rather than blame

- **Publication and Implementation:** within 6 months.



LCSPR Key Principles and Best Practice

Child Centred Approach: The child's perspective and voice must be central to the review, ensuring that their lived experience is understood.

Systems Methodology: Reviews should follow a "systems approach" looking at how organisational structures and inter-agency dynamics influenced professional decisions. **The process is for learning not accountability.**

Proportionality: The review's scale should match the complexity of the case, focussing on where ethe greatest learning potential exists.

Transparency: Rationale for decisions- including whether to conduct a review or publish a report- must be clearly recorded and communicated to families.

Family Engagement: Families and surviving children should be invited to contribute early on in the process. Best practice involves managing their expectations sensitively and providing a dedicated point of contact.

Practitioner Involvement: Agencies should hold "Learning Events" or workshops where frontline staff can provide context on why certain decisions "made sense at the time".

Immediate Action: Safeguarding Partners should not wait for the final report (which can take up to 6 months) to implement changes: immediate learning from the Rapid Review should be actioned instantly.

Anonymisation: Reports must be carefully redacted to protect the identity of the child and family while maintaining the integrity of the learning.



Things to Consider

Proportionality and Scope of the Review:

- **Decision making:** Are the criteria in Working Together (2023) consistently applied when deciding which cases progress to LCSPR or are you defaulting to full reviews, where a less resource- intensive option, like a learning event, might be more effective?
- **Focus:** Does the scope of the review remain focussed on systemic learning and improvement (***the why***) rather than drifting to individual blame?

Commissioning a Reviewer:

- **Expertise:** are you prioritising their ability to analyse complex systems and human factors over their availability or cost?
- **Independence:** Is there a clear separation of roles between the Independent Reviewer and Independent Scrutineer, as stipulated in guidance to ensure robust challenge and accountability?
- **Competence:** does the commissioning process ensure that the reviewer has the necessary skills to facilitate a non punitive, reflective environment for all agencies involved?



Things to Consider

Key Lines of Enquiry:

- **From the Rapid Review:** are the KLOE a direct, logical development of the findings and questions raised during the initial Rapid Review?
- **Voice of the Child:** Do our enquiries ensure that the child's perspective and lived experience is at the heart of the consideration?
- **Multi Agency Focus:** Do the KLOE genuinely test multi agency effectiveness or focus on single agency process?

Family Engagement:

- **Involvement:** Have we clearly articulated ***who*** in the family will be involved and ***why***, ensuring we have considered reasonable adjustments or advocacy support to facilitate meaningful engagement?
- **Influence:** Are families given a genuine opportunity to influence the focus of the review and provide feedback on the final report before its completion?
- **Support:** Are the family's needs and vulnerabilities (e.g., mental health, trauma) properly considered and managed during communication, ensuring a sensitive and supportive process?



Things to Consider

Legal Advice:

- **Process Integrity:** Is legal advice sought early to ensure the LCSPR process is robust and fair, particularly regarding the interface with any parallel criminal investigations, Coronial process or family proceedings?
- **Disclosure:** Are we clear on the legal requirements for information sharing and disclosure of material to relevant parties (including the family or during potential future legal proceedings)?

Publication:

- **Impact Management:** Have safeguarding partners carefully considered how the publication will affect the children involved, their family members, and practitioners, ensuring the report is written in a way that avoids causing further harm?
- **Accessibility & Transparency:** Is the final published report accessible, jargon-free, and available for at least one year to ensure transparency and wide dissemination of learning?
- **Dissemination Strategy:** Do we have a clear, multi-layered communication strategy (e.g., briefings, workshops, audits) to ensure the learning is embedded across all agencies and understood by frontline staff, not just senior leaders?

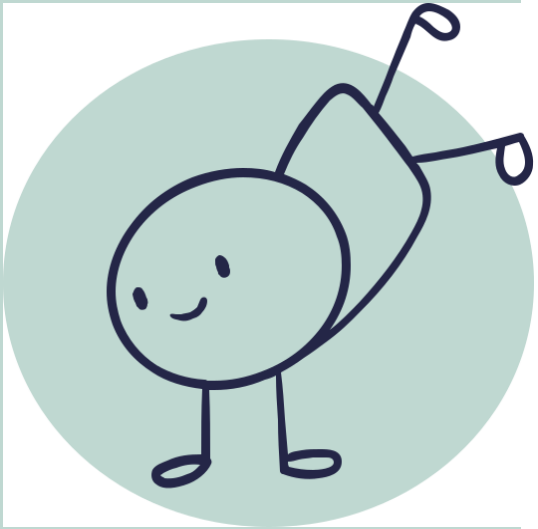


Practice Review Methodologies

Systems Learning Principles and Key Assumptions:

Learning processes are designed to:

- Understand how agencies worked together
- Identify system strengths and weaknesses
- Improve multi agency safeguarding practice
- Promote a learning culture rather than a blame culture



Key Assumptions:

- Harm rarely occurs because of one mistake
- Practice is shaped by organisational conditions
- Frontline decisions often make sense given the context at the time
- Learning should improve systems, not just individual performance

Systems Learning Analysis

Levels of Systems Analysis:

Reviews examine safeguarding practice across:

- **Frontline Practice-** Risk assessment, and decision making
- **Team/ Supervision-** Support, oversight, workload
- **Organisational Systems-** Policies, training, resources
- **Multi Agency Working-** Communication, thresholds, collaboration
- **Wider context-** National policy, funding, societal factors



Strengths and Outcomes of Systems Methodology

Strengths

- Promotes honest professional reflection
- Identifies root causes of safeguarding failures
- Improves multi-agency working
- Supports long-term system improvement

Expected Outcomes

- Improved safeguarding processes
- Better decision-making support
- Enhanced collaboration between agencies
- Stronger child protection systems



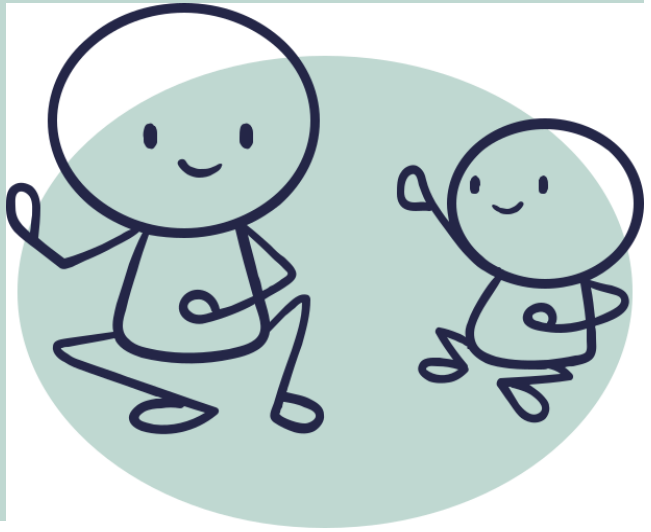
Embedding Learning

MASAs must ensure that findings from reviews lead to real improvements in safeguarding practice, culture, and outcomes for children.

Translate Learning into Action
Convert recommendations into clear, measurable action plans
Identify ownership, timescales, and success criteria
Prioritise systemic learning, not individual blame

Share Learning Effectively
Use briefings, workshops, supervision, and team discussions
Tailor messages for different professional groups
Use real case examples to support understanding

Strengthen Workforce Practice
Embed learning into training, policies, and procedures
Use reflective supervision to reinforce learning
Encourage professional curiosity and challenge



Embedding Learning

Monitor and Evaluate Impact

Track implementation through audits and performance data

Seek feedback from practitioners and partners

Evidence how practice and outcomes for children improve

Promote a Learning Culture

Encourage openness, transparency, and psychological safety

Support multi-agency collaboration and shared responsibility

Regularly revisit learning to ensure sustainability



Over to you!



"What would good look like if our Rapid Reviews & CSPRs were fully achieving their purpose for children and families?"

North West
Children's Safeguarding Partnership

