**One Minute Guide**

**Local Child Safeguarding Practice Reviews (LCSPR or CSPR)**

**The purpose of a Local Safeguarding Child Practice Review is for organisations and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children.**

**It is not an inquiry into how a child died or was seriously harmed, or into who is culpable. These are matters for coroners and criminal courts, respectively, to determine as appropriate.**

When a serious incident becomes known to the safeguarding partners, they must consider whether it meets the criteria for a local review. Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. It is for partners to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice.   
  
Issues might appear to be the same in some child safeguarding incidents but reasons for actions and behaviours may vary resulting in different learning to be gained from similar incidents. Decisions on whether to undertake reviews should be made transparently and the rationale communicated appropriately, including to families.

**Criteria for a Review**  
The criteria which the local safeguarding partners must take into account (which would normally be considered at the end of a ‘Rapid Review’ process) when determining whether to carry out a local child safeguarding practice review includes 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.
* Recurrent themes in the safeguarding and promotion of the welfare of children.
* Concerns regarding two or more organisations or agencies failing to work together effectively to safeguard and promote the welfare of children.
* Or is a case 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 they have cause for concern about the actions of a single agency.
* There has been no agency involvement with the child / family prior to the incident and this causes for concern.
* More than one local authority, police force area or clinical commissioning group is involved, including in cases where families have moved around.
* The case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings (this includes children's homes (including secure children's homes) and other settings with residential provision for children; custodial settings where a child is held, including police custody, young offender institutions and secure training centres; and all settings where detention of a child takes place, including under the Mental Health Act 1983 or the Mental Capacity Act 2005).

**Decision to Undertake a Review**  
Some Incidents involving Children or Young People may not meet the definition of a 'serious child safeguarding case' but the safeguarding partners may choose to undertake a local child safeguarding practice review because they raise issues of importance to the local area, for example good practice, poor practice or where there have been 'near miss' events.

As soon as safeguarding partners have determined that a local review will be carried out, they will inform the Child Safeguarding Practice Review Panel (aka the ‘National’ Panel) Ofsted and Department for Education (DfE), including the name of any reviewer they have commissioned. The Safeguarding Partners will need to source and appoint an appropriate Independent Reviewer and Chair for the meetings.

**Undertaking the Review**The safeguarding partners (Local Authority, ICB/Health and Police) should agree with the reviewer(s) the method by which the review should be conducted, taking into account Working Together guidance and the principles of the systems methodology recommended by the Munro review. The methodology should provide a way of looking at and analysing frontline practice as well as organisational structures and learning. The methodology should be able to reach recommendations that will improve outcomes for children. All reviews should reflect the child’s perspective and the family context.

The review should be proportionate to the circumstances of the Incident, focus on potential learning, and establish and explain the reasons why the events occurred as they did.

As part of their duty to ensure that the review is of satisfactory quality, the safeguarding partners should seek to ensure that:

Practitioners are fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

Families, including surviving children, are invited to contribute to reviews. This is important for ensuring that the child is at the centre of the process. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

**Safeguarding partners must ensure that the final report includes:**

• a summary of any recommended improvements to be made by persons in the area to safeguard and promote the welfare of children

• an analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report.

Any recommendations should be clear on what is required of relevant agencies and others collectively and individually, and by when, and focussed on improving outcomes for children. Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond, so safeguarding partners must publish the report, unless they consider it inappropriate to do so. In such a circumstance, they must publish any information about the improvements that should be made following the review that they consider it appropriate to publish. The name of the reviewer(s) should be included. Published reports or information must be publicly available for at least one year.

**Useful Links/Further Information**

Working Together ([Statutory](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf) Guidance) [NSPCC Cas Review Repository website](https://learning.nspcc.org.uk/case-reviews/national-case-review-repository) [The National Safeguarding Panel](https://www.gov.uk/government/organisations/child-safeguarding-practice-review-panel)