Kingston and Richmond
Safeguarding Children Partnership

KRSCP Guidance for the review of serious child safeguarding cases and the case review subgroup

Purpose

This KRSCP guidance describes how the partnership will be notified of and review serious child safeguarding cases through the work of the Case Review Subgroup (please see the Case Review Subgroup Terms of Reference also). The guidance is intended to function as a toolbox to support the work of the subgroup.

Context

According to legislation and accompanying government guidance, reviews of serious child safeguarding cases should be undertaken, according to the criteria, to identify improvements to be made to safeguard and promote the welfare of children. At a local level responsibility for this work lies with the safeguarding partners and at a national level, with the national Child Safeguarding Practice Review Panel (to be referred to in this document as the national panel).

The following guidance is relevant to this document:

Working Together to Safeguard Children 2018

Child Safeguarding Practice Review Panel guidance for safeguarding partners – September 2022

Definition of a serious child safeguarding case

Working Together to Safeguard Children 2018 defines serious child safeguarding cases as those in which:

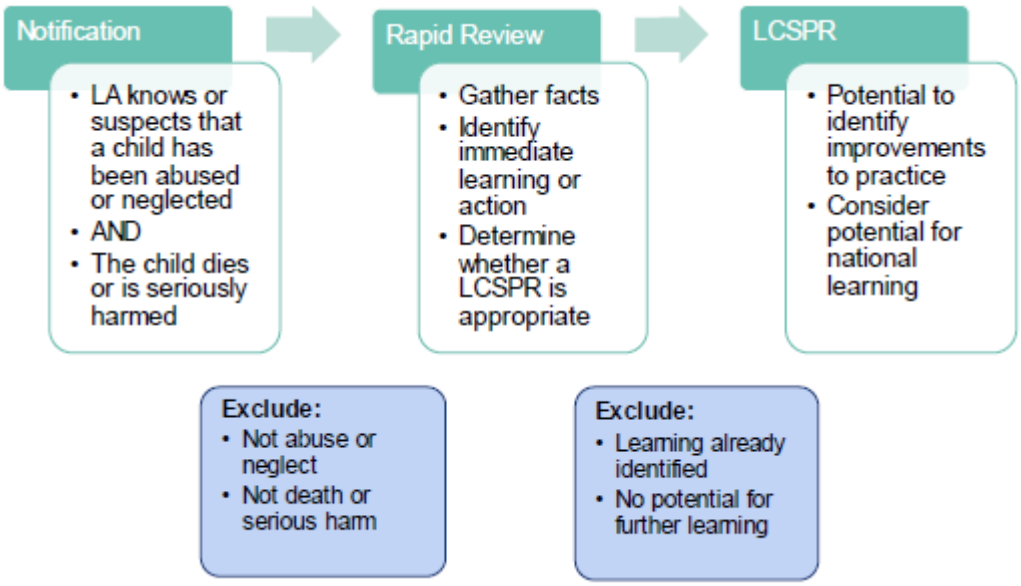
- Abuse or neglect of a child is known or suspected; **and,**
- The child has died or been seriously harmed.

Serious harm includes (but is not limited to) serious **and/or** long term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health (child perpetrators may also be the subject of a review, if the definition of 'serious child safeguarding case' is met). This is not an exhaustive list. When making decisions, judgement should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.

Further guidance on how to interpret the above definition and its terms i.e. abuse, neglect and serious harm, as well as typical circumstances in which a notification may or may not be appropriate, can be found on pages 9-13 Child Safeguarding Practice Review Panel guidance for safeguarding partners – September 2022

Decision making

The following gives an overview of the considerations for decision making re referral and review of potential serious child safeguarding cases:



Notification

The duty to notify a serious child safeguarding case lies with the local authority and this responsibility is delegated locally to the Associate Director for Quality Assurance and Review in Achieving for Children, who provide children's services on behalf of the Royal Borough of Kingston upon Thames and the London Borough of Richmond upon Thames.

Detailed guidance for the process that AfC must undertake is available:

https://www.gov.uk/guidance/report-a-serious-child-safeguarding-incident

The following key principles are:

- Notifications should be made if a child dies or is seriously harmed (either in your area, or outside of England but who is normally resident in your area), and it's known or suspected that the child has been abused or neglected;
- The national panel should also be notified of the death of any looked after child whether or not abuse or neglect is known or suspected (where there are no concerns regarding abuse or neglect a rapid review will not be required);
- Notifications should be made within 5 working days of becoming aware of the incident;
- The national panel will share the notification with Ofsted and the Department for Education; and,
- The local safeguarding children partners/partnership should also be notified (notification to other partnerships should be considered for example if it were a death of looked after child placed out of area).

When making a notification to the national panel, AfC will notify KRSCP via email to the Partnership Manager on the same day, this will in turn be shared with the core strategic leadership group (SLG) for their information.

Generally, AfC will be aware of serious child safeguarding cases however there may be occasions when other agencies are first aware of incidents that may meet the threshold for notification. In these instances, they should be notified to the Associate Director for Quality Assurance and Review, copying in KRSCP (see appendix 1 for proforma and contact details), and a discussion should be held to facilitate agreement as to whether the incident is notified.

The national panel notes that good practice suggests that the local authority should wherever possible consult with other safeguarding partners when deciding whether to notify.

If there is disagreement about whether to notify, the incident should be escalated to the SLG urgently for their consideration (within 5 working days). In turn, KRSCP SLG should consider consulting the independent scrutineer if there is continued dissent.

Rapid review

Once a notification has been made to the national panel of a serious child safeguarding case, the responsibility for a rapid review rests with the three safeguarding partners.

The key principles are as follows:

- Rapid reviews should identify, collate, and reflect on the facts of the case as quickly as possible in order to establish whether there is any immediate action needed to ensure a child's safety and potential for practice learning;
- For safeguarding partners, the rapid review should conclude with a decision about whether an LSCPR should be commissioned using the criteria set out in WT2018;
- If the decision is to commission a LCSPR, the key lines of enquiry and the questions that are to be answered by the review process should be set out in the conclusion to the rapid review; and,
- Good practice is where partnerships identify what has been learnt and how this learning will be disseminated and acted on across the local partnership.

It is the national panel's expectation that any case which is subject to rapid review should have been notified to the panel. If the panel received a rapid review which has not been notified, they will ask the LA to submit a notification.

Following receipt of a notification of a serious child safeguarding case made by AfC on behalf of the LA to the national panel, the partnership team will notify all relevant agencies of the incident and the need to convene a rapid review and request chronologies to support this via an agreed template or chronology tool (*KRSCP intends to trial the Chronolator tool locally from Spring 2023). These must be completed and returned within 5 working days. The rapid review will also seek minutes of any meetings held as part of a joint agency response in the event the case concerns a child death.

The partnership team will book a rapid review meeting (separate to the standing meetings of the case review subgroup) to be held 10 working days from the notification of incident. Chronologies will be shared with attendees 5 working days before the meeting and invitees are expected to attend having read the collated information and prepared to share their analysis of their own agency and multiagency practice and contribute to decision making and identification of learning and related actions. There may be professionals who are not part of the case review subgroup who have relevant input, who will be invited to contribute to the rapid review meeting on an ad hoc basis in an advisory capacity.

Rapid reviews will be captured and written up using the template at appendix 2. Case review subgroup members and other ad hoc participants may like to use this template as a tool for note making to support their contribution to the rapid review meeting.

Once the meeting has been held the partnership team will write up the discussion using this template and share for agreement with the rapid review chair(s), and the three strategic safeguarding partners and/or their delegated leads for sign off prior to submission to the national panel, 15 working days from notification.

The agreed rapid review report will be submitted to the national panel by the partnership team via email to Mailbox.NationalReviewPanel@education.gov.uk

A copy will also be shared with the case review subgroup and contributing agencies for their information.

Where a rapid review has already identified relevant learning and there does not appear to be any scope for further learning to be gained through a local child safeguarding practice review (LCSPR), the safeguarding partners should outline how learning already identified will be disseminated and acted on, or how the learning outcomes have been achieved. This should be clearly expressed in the rapid review and an appropriate action plan developed.

The 15 days' timescale for rapid reviews should be adhered to generally irrespective of information that may be pending (for example post mortem results) as the focus is on practice prior to the incident. If there are extenuating reasons why the rapid review cannot be completed within 15 working days, the panel secretariat should be notified at Mailbox.NationalReviewPanel@education.gov.uk.

The national panel aim to respond to reviews received within 15 working days generally by letter which will confirm their views on the case and provide feedback on the decision making, analysis and learning, or to request further information. Their feedback will be shared with SLG and the case review subgroup and other interested parties, by the partnership team once received.

The case review subgroup is responsible for overseeing the outcomes of all rapid reviews and these will be logged on the serious child safeguarding case tracker.

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. An incident meeting the criteria does not mean there is an automatic expectation to carry out an LCSPR. The focus should be on whether a LCSPR will identify new learning that is not yet available or tackle perennial problems. The rapid review should include a clear rationale for cases where a LCSPR is recommended.

It is not expected that families will be informed of or involved in rapid reviews; however, LA partners should consider whether to inform families that they are notifying the incident as a serious child safeguarding case, and safeguarding partners should give consideration to whether and how any learning and recommendations arising from rapid reviews is shared with families.

Generally responsibility for a rapid review and any subsequent LCSPR will sit with the partnership where the child was ordinarily resident (or typically to whom they are looked after in case of children looked after); however, there should be liaison with other partnerships in the event that a joint approach is indicated – for example if a child ordinarily resident in Kingston or Richmond is

harmed elsewhere (not abroad) it becomes the responsibility of that local authority to notify but may be most appropriate for us to lead on the rapid review.

Local Child Safeguarding Practice Reviews

In cases where a recommendation is made to proceed to LCSPR and this is endorsed by the national panel, a review will be commissioned and all relevant providers and safeguarding children partnerships, notified formally by the partnership team (note the decision to commission a LCSPR rests with the statutory safeguarding partners, so they may proceed with one irrespective of if the national panel supports this plan).

Whoever is tasked with undertaking the review they should have suitable skills in applying a systems approach as outlined in WT2018. Partners should consider the following re potential reviewers:

- Professional knowledge, understanding and practice relevant to local child safeguarding practice reviews, including the ability to engage both with practitioners and children and families;
- Knowledge and understanding of research relevant to children's safeguarding issues;
- Ability to recognise the complex circumstances in which practitioners work together to safeguard children;
- Ability to understand practice from the viewpoint of the individuals, organisations or agencies involved at the time rather than using hindsight;
- Ability to communicate findings effectively; and,
- Whether the reviewer has any real or perceived conflict of interest.

In KRSCP a range of multiagency professionals have been trained in the Social Care Institute for Excellence Learning Together Model for systems reviews. This means there is capacity both for commissioning and undertaking systems reviews where appropriate within the partnership.

There may be cases where an independent reviewer with specialist expertise is indicated. The case review subgroup will consider who may be appropriate and make a recommendation but ultimately this decision is for SLG.

Generally, in cases where it is considered an independent reviewer is indicated, expressions of interest will be sought from at least three reviewers/agencies and a decision made by the SLG with support from the case review subgroup.

LSCPRs will be supported by a range of local professionals often referred to as a panel, identified by the case review subgroup and agreed by SLG. It is important that this group has an appropriate range of experience. Where nominated professionals are new to participating in LCSPRs, it is the expectation that they will be supported by one or more of the case review subgroup members from their organisation.

Key principles for LSCPRs are as follows:

- They should be named consistently as LCSPRs;
- They should include appropriate involvement of practitioners and families;
- There is an expectation that the report from the LCSPR will be published within 6 months;
- LCSPRs should use a systems methodology and get behind why things happened not just how and what;
- The scope, aims, and terms of reference of the LCSPR should be determined at the start and specified in the report. These should stem from the learning identified in the rapid review;

- Reports should respond to the identified key lines of enquiry (the national panel recommends no more than 3 or 4 key questions);
- Key practice episodes can be used to analyse significant events;
- The child's voice should be dominant throughout;
- The review must consider characteristics of a child's identity and to what extent this may have impacted professional decision making; and,
- Partnerships should be mindful of intersectionality when considering the usefulness of an LCSPR.

It is acknowledged that sometimes there may be parallel processes such as criminal investigations and proceedings that may mean the partnership is inclined to delay the LCSPR process until the conclusion of these. National panel guidance emphasises that in most cases it should be possible to progress these alongside other processes as their focus is different. Detailed guidance should be accessed at pages 22-23 of Child Safeguarding Practice Review Panel guidance for safeguarding partners – September 2022

Generally, LCSPRs should be completed within 6 months of the partnership deciding to undertake a review. Any delays in this timescale should be communicated to the national panel and the Secretary of State for Education with the reasons.

The scope, aims, and terms of reference should be determined at the start and specified clearly in the report. The partnership team will help develop draft terms of reference according to a local template which can be elaborated upon once reviewer(s)/review team have been appointed (see appendix 3). A pseudonym will be allocated to the review from the outset to ensure there is a working anonymisation that supports keeping in mind individual people affected; if the family wishes to participate in the review, they will be given the opportunity to identify a pseudonym that is meaningful to them which may be used for publication.

The partnership will have standardised easy read materials and a cover letter for sharing with families to inform them about a review and invite them to participate (see appendix 4). Where possible these will be shared with the family by an appropriate lead professional. Generally family members will be invited to meet with the reviewer(s) to gather their views and experiences and test emerging learning, and then offered a further meeting to share the findings and how they will be shared including receipt of the final report.

Safeguarding partners must ensure that final reports:

- Provide a summary of any recommended improvements to be made by persons in the area to safeguard and promote the welfare of children;
- Include an analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report; and,
- 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.

The partnership will ensure all reports from reviews are written for publication and consider carefully how to manage impact on family and practitioners; however, for each LCSPR the final decision as to whether it is appropriate to publish will rest with SLG and be communicated to the national panel. Completed reviews will be shared with the national panel with details of the proposal for publication or justification as to why the review is not being published (at least 7 days prior to publication if this is being undertaken). Completed reviews should also be shared with the Secretary of State for Education.

In these instances, the partnership must consider publication of any information about the improvements that should be made following the review that they consider it appropriate to publish. Where the safeguarding partners decide only to publish information relating to the improvements to be made following the review, they must also provide a copy of that information to the Panel. They should also provide the report, or information about improvements, to Ofsted (via SCR.SIN@ofsted.gov.uk) and the Secretary of State for Education (via Mailbox.CPOD@education.gov.uk) within the same timescale.

The partnership should have regard to any comments the national panel and/or Secretary of State for Education make with respect to publication.

For any reviews where a decision is made that it is not appropriate to publish them locally due to sensitivity to the family; they may be published anonymously via the NSPCC National Case Review Repository.

Published reports or information must be publicly available for at least one year.

Outcomes from completed LSCPRs will be monitored by the case review subgroup and logged on the serious child safeguarding case tracker. The case review subgroup will have lead responsibility for overseeing the process of consideration of recommendations and devising relevant actions to take forward from reviews, and ensuring these are appropriately allocated across the partnership by agreement with the SLG, and in liaison with subgroup chairs.

Every effort should be made to identify and disseminate learning and take corrective action as the review progresses, rather than being limited to its conclusion.

National child safeguarding practice reviews

In determining whether a national child safeguarding practice review (NCSPR) should be held, the national panel will consider the following criteria upon receipt of a completed rapid review:

The criteria which the Panel must take into account include whether the case[86]:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
- raises or may raise issues requiring legislative change or changes to guidance issued under or further to any enactment
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children

The Panel should also have regard to the following circumstances:

- significant harm or death to a child educated otherwise than at school
- where a child is seriously harmed or dies while in the care of a local authority, or while on (or recently removed from) a child protection plan
- cases which involve a range of types of abuse[87]

  where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings[88]

Likewise, in determining whether a NCSPR may be appropriate, the case review subgroup undertaking the rapid review should include in their report, commentary as to whether the above criteria apply in the relevant section.

The national panel will also consider a range of evidence including inspection reports and other research to inform their decision.

It is anticipated as likely that there will need to be dialogue between the partnership and the national panel to support decision making in cases that may require a national review, and the safeguarding partners must share further information with the national panel as required.

The panel will communicate their decision and rationale as to whether a national review is indicated including to families. They will also notify the Secretary of State for Education, where a national review is being taken forward.

There may be cases where local reviews subsequently form part of thematic reviews undertaken by the national panel. In these cases, there will be liaison between the national panel and the safeguarding partners as to how this is taken conducted.

Expectations for reports from national reviews are broadly the same as for LCSPRs but with some differences for example timescale for public availability – please see page 94-95 of WT2018 for full detail.

Interface with other reviews/parallel processes

WT2018 and national panel guidance makes clear that LSCPRS and national reviews can be undertaken flexibly alongside other reviews for example domestic homicide reviews and safeguarding adult reviews, to ensure the learning is identified collaboratively and the review processes are proportionate and minimise burden on families. There should be communication from the outset between the different bodies involved to agree how this will be managed. When undertaking a joint report, it is important to ensure that the key requirements of both processes are clearly identified and met.

Where there are criminal or coronial investigations, there should be liaison with the necessary police/coronial leads to ensure the review can progress alongside whilst minimising/mitigating risks to those proceedings - see pages 22-23 of Child Safeguarding Practice Review Panel guidance for safeguarding partners – September 2022.

Monitoring outcomes and impact

The partnership will monitor outcomes and impact of the learning from all reviews (rapid, local and national) through a tracker to be maintained by the partnership team and overseen by the case review subgroup.

The tracker will be developed to aid thematic analysis.

Learning from serious child safeguarding cases, how it is shared and its impact, will be included in the KRSCP annual report. The annual report will be shared with the national panel (via NationalReviewPanel@education.gov.uk) and the What Works Centre for Children's Social Care (WWCSC).

Appendix 1

Serious Child Safeguarding Case Notification

A serious child safeguarding case notification should be undertaken by AfC to the national child safeguarding practice review panel for the following:

To be completed when:

- *A child dies or is seriously harmed where abuse or neglect is known or suspected (where the harm occurs in Kingston or Richmond and/or the child resides there).*
- *A child dies or is seriously harmed outside England where abuse or neglect is known or suspected, who is normally resident in Kingston or Richmond*
- *A looked after child has died (irrespective of whether abuse or neglect are known or suspected, please include details if these concerns do apply)*

In instances where this information may be first held by another agency and/or there is disagreement about the application of threshold, the following details should be completed and emailed securely to:

Carrie Mark Associate Director for Quality Assurance and Review: Caroline.mark@achievingforchildren.org.uk and copy to Susan.ogden@achievingforchildren.org.uk

Please also copy in the KRSCP Manager daksha.mistry@kingrichlscb.org.uk

1. Name, date of birth, date of death if applicable, NHS Number, details of any disabilities/health/learning needs, ethnicity, address of child, which borough the child resides in or is looked after by:

2. Name of parents, their address if different from the child and whether they hold parental responsibility:

3. Name of any other significant household members for example siblings, step-parents etc.

4. Details of all agencies involved with child and family

5. Information regarding the incident including date, time and place including borough:

6. Details of any immediate safeguarding arrangements/needs:

Appendix 2

Kingston and Richmond
Safeguarding Children Partnership

Rapid Review Report
Date:
Time:
Location:

Details of child:

Name	
Age	
Date of birth	
Date of death (if applicable)	
Gender	
Ethnicity	
Known health needs including disability (if applicable)	

Other family/household members:

Name	
Age	
Relationship to child	
Date of birth	
Date of death (if applicable)	
Gender	
Ethnicity	
Known health needs including disability (if applicable)	

Name	
Age	
Relationship to child	
Date of birth	
Date of death (if applicable)	
Gender	
Ethnicity	
Known health needs including disability (if applicable)	

Any additional information of note:

Summary of serious incident and relevant context:

Supporting information

Agency	Submitted chronology/similar	Represented at rapid review
Achieving for Children – Children's Social Care		
Achieving for Children – Education related		
Achieving for Children – Emotional Health Service		
South London Legal Partnership		
Hounslow & Richmond Community Healthcare		
South West London Integrated Care Board Designated Safeguarding Team		
Kingston Hospital		
Metropolitan Police Service		
South West London St George's Mental Health Trust (CAMHS Tier 3 and acute adult mental health services)		
LA Public Health		
Your Healthcare		
Central London Community Healthcare NHS Trust		
Chelsea & Westminster Hospital NHS Trust (West Mid)		
GP		
Education for example school, nursery etc		

Any information not gathered/included at time of rapid review meeting?

Immediate safeguarding arrangements of any children involved:

Consideration of the serious incident

Important issues to consider in this section include:

- *The child's lived experience and how their voice can 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?*
- *Does this case highlight improvements needed to safeguard and promote the welfare of children?*
- *Does this case highlight recurrent themes in safeguarding and promotion of the welfare of children?*
- *Does this case highlight concerns regarding either single or multiagency working?*

What are the issues and learning identifiable?
Are there examples of good practice?

Contextual information

Are there any relevant local or national reviews that relate to the potential learning in this case?

Decision making

Has child died or been seriously harmed?
Yes/No
Is abuse or neglect known or suspected?
Yes/No
Are the criteria for a child safeguarding practice review met (see boxed content at end of document)?
Does the partnership consider there is additional learning, beyond existing local and national reviews or similar, which could be determined through a child safeguarding practice review?
Yes/No
Is a local child safeguarding practice review (CSPR) recommended?
Yes/No
What is the rationale for this decision?
If a CSPR is indicated what are the key lines of enquiry and/or research questions that the partnership would like to explore?
Is a national child safeguarding practice review is recommended?
Yes/No
Is any other form of review indicated, including where a CSPR is not recommended?
Yes/No, details as applicable
Is there any learning identified by this rapid review and how will it be shared?

The criteria which the local safeguarding partners must take into account include whether the case[83]:

- 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[84]

Appendix 3

Kingston and Richmond
Safeguarding Children Partnership

KRSCP Local Child Safeguarding Practice Review re Insert detail – Terms of Reference

This local child safeguarding practice review (LCSPR) has been instigated by Kingston & Richmond Safeguarding Children Partnership (KRSCP) under the auspices of Working Together 2018.

A referral was made to the case review subgroup by Achieving for Children on Insert detail.

A rapid review was held on Insert detail and concluded an LCSPR was recommended. This was agreed by KRSCP SLG and the national panel.

Brief summary of the serious child safeguarding case

Insert detail

What are the wider systems issues or areas that we want to learn about?

The reviewers propose the following research questions subject to agreement with senior stakeholders:

Insert detail

What time period of the case do we need to look at to explore these issues?

Insert detail

Which agencies/individuals need to participate?

Organisations to be involved in the review are listed in Appendix 1.

What further information needs to be gathered from the relevant agencies?

Insert detail

What vulnerabilities, sensitivities and/or tensions are there for individuals and agencies around this case?

Insert detail

Who needs to be informed from the person, their representatives, advocates or family members? What options can we offer them for contributing to the review?

Insert detail

Who will lead this review?

Insert detail

Methodology

Insert detail

Research evidence

Insert detail

The review report

The review report will be prepared following collation of chronologies, practitioner meetings/events, and engagement with family. This is to be written with the expectation that it will be published.

A proposed timeline is found at Appendix 2.

Support for the review

Insert detail

Appendix 1

Organisations identified so far, to be involved in the review:

Insert detail

Appendix 2

Proposed outline timeline for review (**to be tailored according to chosen methodology, engagement of independent reviewer etc*):

What	When	Lead
Lead Reviewer(s) to be agreed/commissioned		
Reviewer(s) to meet and determine individuals to be invited to senior stakeholder meeting (review team)		
Chronologies to be received and merged and shared with reviewers		
Develop timeline: identify practitioners/managers and agencies and key documents to source and read.		
Senior stakeholder meeting of involved agencies (Review team) to agree organisational research questions		
Practitioner meeting: Introduce everyone to methodology to be used in the LCSPR		
Inform family about review in liaison with appropriate practitioners and consideration to support needs		
Reviewer(s) identify key practice episodes and draft analysis using available data		
Family members supported to participate if they wish to		
1st Practitioner workshop: Input from practitioners to – • Appreciate 'view from the tunnel'		

• Finesse KPE analysis by discussing appraisal and identifying contributory factors • Discussion potential systems findings		
Reviewer(s) update KPEs from workshop, draft case findings summary and systems findings		
2nd Review team meeting: input data to test and finesse draft systems findings and agree case findings summary		
2nd Practitioners workshop to share final draft systems findings to check challenge and amplify; and discuss case findings summary.		
Reviewers finalise write up of case findings summary, systems findings, and final report		
Report considered by Local Learning Review Subgroup. LLR subgroup to consider: • Any further data to support or challenge systems findings • Sensitivity check of case findings summary		
Family informed of findings		
Reviewers finalise report		
Report presented to SLG – SLG to agree how partnership will take learning forward		

Appendix 4

Kingston and Richmond
Safeguarding Children Partnership

INSERT DETAIL

INSERT DATE

Dear INSERT,

Confidential: Local Child Safeguarding Practice Review

Kingston & Richmond Safeguarding Children Partnership (KRSCP) help protect children from harm.

When children are seriously harmed, we collect and share information to understand what happened.

The information we collect helps us to learn how to protect children better.

This process is known as a child safeguarding practice review.

KRSCP are holding a child safeguarding practice review regarding INSERT DETAIL

INSERT DETAIL has been chosen to lead this review.

I would like to invite you to talk to me about your experiences, if you would like to. We could meet in person or virtually. You are welcome to have anyone present that you feel would be helpful support you. If you would like to meet with me, we can make a plan to do this through INSERT DETAIL

When the review is complete there will be a report which will be published. This report is published so people can read and learn from it.

The report will not identify you or others involved. We will share its contents with you prior to publication.

All the information shared with this review will be kept confidential and safe and we will only use it to assist our work in protecting children. There is a privacy notice with this letter that has more information about how we use information.

Yours sincerely,

INSERT DETAIL

Quick Easy Read
Privacy Notice - KRSC