Briefing: Purpose of a Rapid Review for Participants

What is a Rapid Review?

Following the notification of a Serious Child Safeguarding Incident (SCSI) to the National Child Safeguarding Practice Review (CSPR) Panel by the Local Authority, in agreement with the other Statutory Partners (MPS and ICB), there is a requirement under Working Together to Safeguard Children for the Statutory Partners to undertake a Rapid Review for completion within 15 working days of the notification.

A Rapid Review is a multi-agency process which considers the circumstances of a SCSI. The purpose of the Rapid Review is to identify and act upon immediate learning and consider if there is additional learning which could be identified through a wider Child Safeguarding Practice Review (CSPR).

What is a Child Safeguarding Practice Review (CSPR)?

If the Rapid Review identifies that there is further learning from a particular incident which has not been fully identified and explored through the Rapid Review, the Local SCP must commission a Child Safeguarding Practice Review (CSPR). The purpose of a CSPR is to explore how practice can be improved through changes to the system itself.

In addition, the Redbridge Safeguarding Children Partnership has a duty to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. This may be in the form of a CSPR or another review process. The final decision with regards to initiating a CSPR lies with the Executive.

Why do we have Rapid Reviews and CSPRs?

The purpose of Rapid Reviews and CSPRs is to identify lessons that require improvements to be made to policies, procedures, and practice. Reviews are not ends in themselves; lessons must be used to improve practice, manage risks better and enhance outcomes for

children and young people. The reviews focus on systems and how agencies work together to safeguard children and young people although the actions of individuals may come under scrutiny.

Criteria for undertaking a CSPR

The criteria which the local safeguarding partners must consider 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).

Some cases 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.

What is the difference between a JAR or Rapid Response Meeting?

Following the death of a child the following guidance must be followed Child Death Review Statutory Operational guidance. Included in the guidance is what to do when a child or infant dies unexpectedly.

Part of this guidance is to initiate a JAR (Joint Agency Response) meeting as soon as possible.

These joint investigative procedures are often referred to as the 'rapid response', which can cause confusion with the Child Safeguarding "Rapid Review".

A joint agency response (JAR) is a coordinated multi-agency response by the lead health professional, police investigator, duty social worker and should be triggered if a child's death:

- Is or could be due to external causes.
- Is sudden and there is no immediately apparent cause (including SUDI/SUDC).
- Where initial circumstances raise any suspicions that the death may not have been natural.
- Occurs in custody or a death whilst detained by the state including under the mental health act.
- In the case of a stillbirth where no healthcare professional was in attendance

The aims of these processes are to:

  - Assist HM Coroner in ascertaining a cause of death where possible.
  - Identify any potentially contributory or modifiable factors.
  - Ensure support for families.
  - Assure families that their child's death has been fully investigated.
  - Ensure that future children are protected and satisfy any wider public interest concerns.

If there is suspicion of abuse and or neglect may have contributed to the death at the JAR meeting the case is passed to the Safeguarding Partners for consideration of a Rapid Review.