
# Instigating and Undertaking a Case Review Learning Process

**Wigan Safeguarding Children's Partnership**

| Version | Date | Author / Reviewed by | Comments |
|---|---|---|---|
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## 1 Introduction by Colette Dutton – Independent Chair Wigan Safeguarding Children's Partnership

1.1 Wigan Safeguarding Children's Partnership is committed to improving the outcomes for, children, young people and their families through its learning and improvement activity. The partnership supports and will incorporate all learning and at all levels from across partner agencies. A separate Learning and Improvement Framework has been commissioned to identify where those opportunities can be harnessed into improving practice, policy and process and commissioning of services to improve outcomes for children, young people, and families.

1.2 This document sets out the case review processes for Children, Young People and Families to ensure that all staff involved are clear in the steps they are asked to follow from referral through to case review reporting, their role within the process and how case reviews will be held and run. The process is designed to ensure that not only statutory requirements in terms of cases that hit threshold of Working Together are set out and clear, but the Wigan model allows for review of cases that might not hit critical threshold. This is to ensure that any learning can be extracted through a robust, inclusive and blame-free process and that cases that can be described variously as "near misses" or even "positive practices / outcomes" can be incorporated within the partnership learning process. The partnership recognises that learning from these cases is often shifting the learning and system changes further upstream from a preventative perspective. In the case of celebrating positive outcomes borne out of individual practitioner skills or partnership working hold as much (if not more) value to multiagency staff than simply maintaining a focus on high threshold and after the event serious incidents.

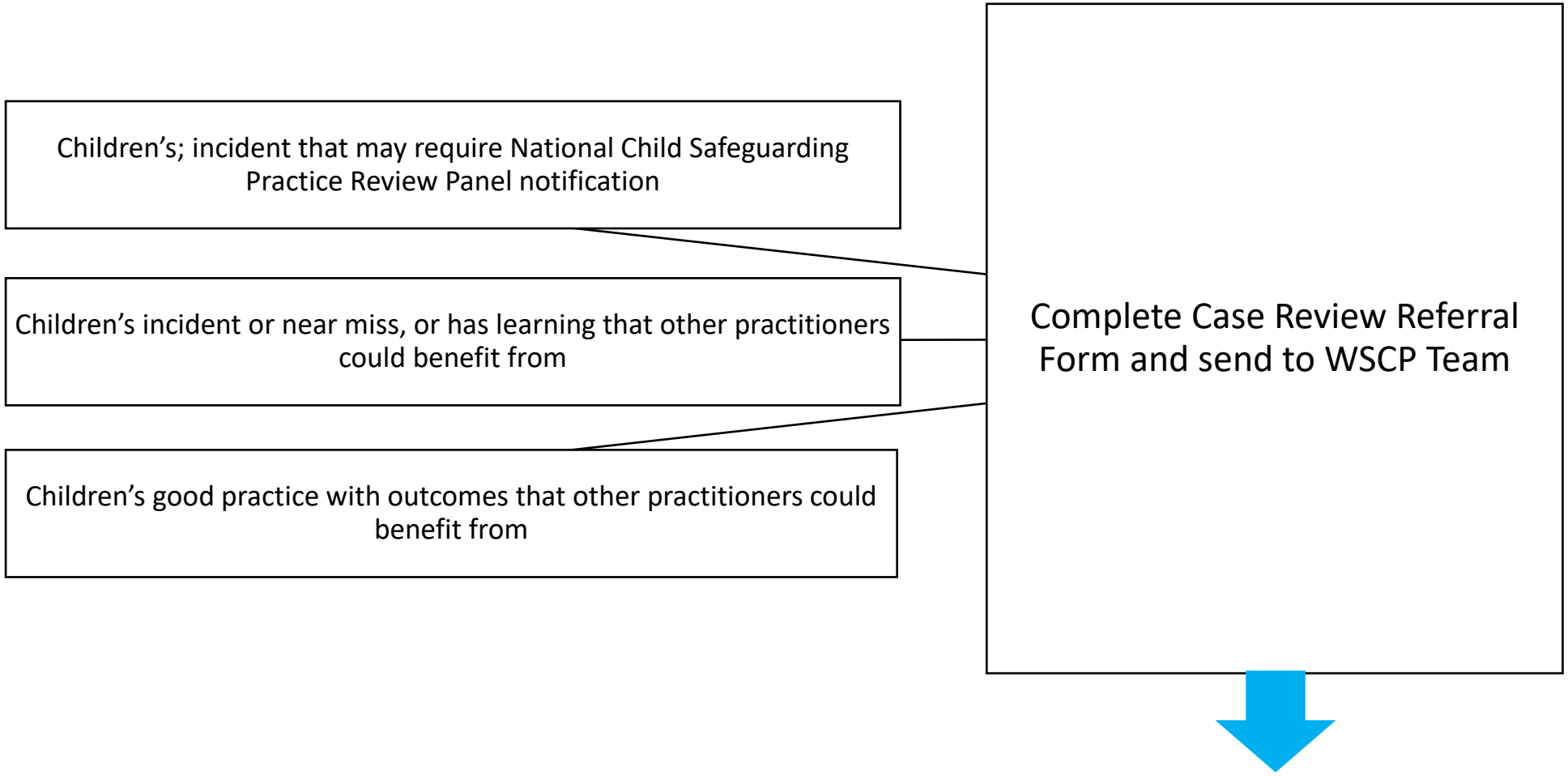
1.3 It also acknowledges that even in the most serious of incidents and case reviews, that Wigan has committed and positive staff across all agencies, and that good practice exists even within the most complex or serious case. The partnership has discussed and will actively promote positive learning throughout the case review process and that does not apportion blame to individuals or agencies – there are processes equipped to deal with this outside of the partnership's core review responsibilities. The onus is on the learning that will change our system responses that in turn lead to better outcomes for children and young people in need of safeguarding in the Borough.

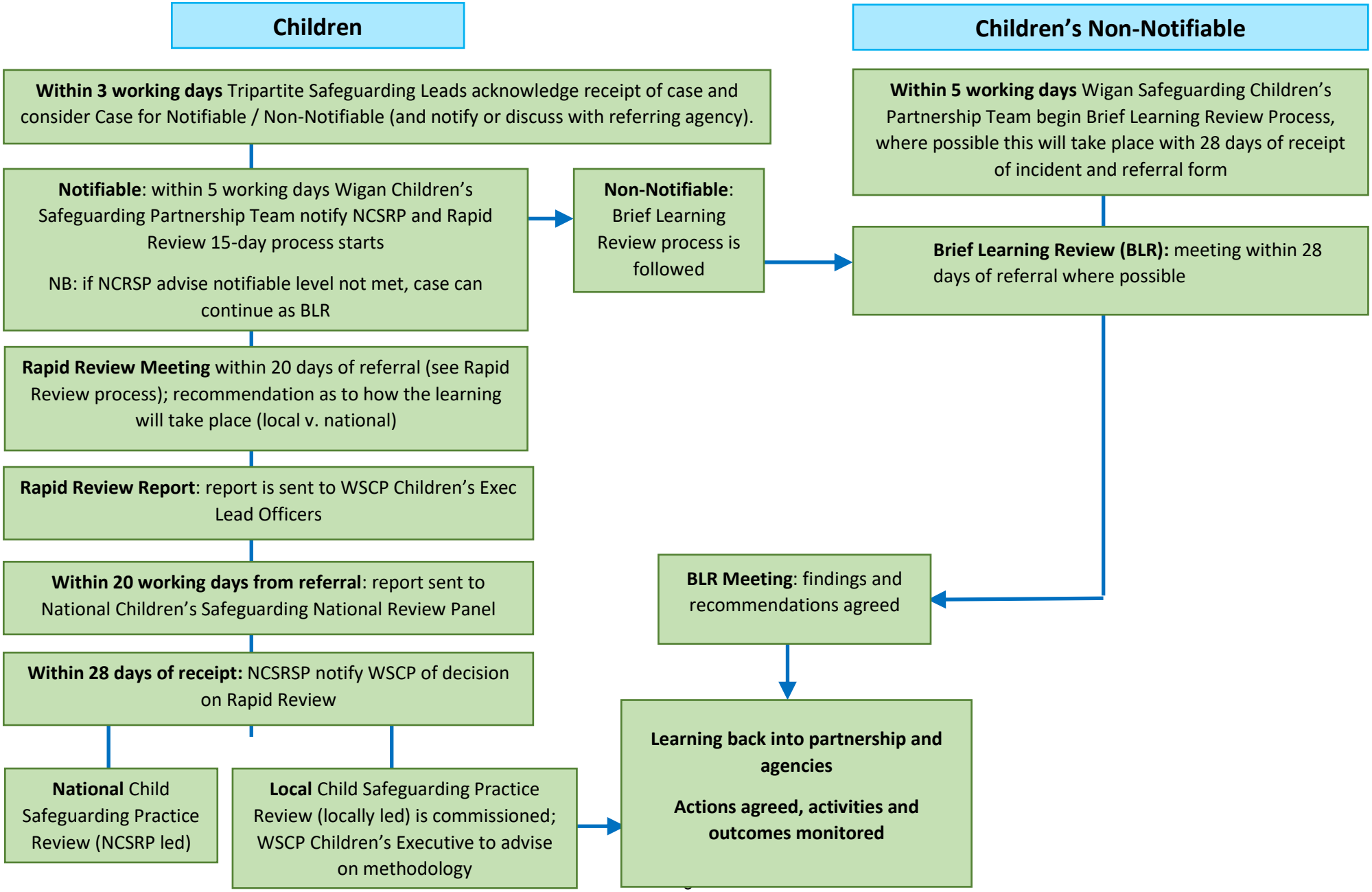
1.4 Put simply, the purpose of conducting case reviews at all levels is not to reinvestigate or to apportion blame, it is:

- To establish whether there are any lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard vulnerable Children young people and families.
- To review the effectiveness of procedures or commissioning of services
- To inform and improve local inter-agency practice
- To improve practice by acting on learning
- To inform training provision
- To highlight good practice

1.5 The partnership will push a positive message across all agencies asking partnership staff to refer in both serious cases, near miss type cases and positive outcome cases, the learning process is the same for all and I urge you to help us improve by learning.

## 2. WSCP Referral Process and Learning Levels for Rapid Reviews / Local Child Safeguarding Practice Reviews




Children
Children's Non-Notifiable
Within 3 working days Tripartite Safeguarding Leads acknowledge receipt of case and consider Case for Notifiable / Non-Notifiable (and notify or discuss with referring agency).
Notifiable: within 5 working days Wigan Children's Safeguarding Partnership Team notify NCSRP and Rapid Review 15-day process starts
NB: if NCRSP advise notifiable level not met, case can continue as BLR
Non-Notifiable: Brief Learning Review process is followed
Within 5 working days Wigan Safeguarding Children's Partnership Team begin Brief Learning Review Process, where possible this will take place with 28 days of receipt of incident and referral form
Brief Learning Review (BLR): meeting within 28 days of referral where possible
Rapid Review Meeting within 20 days of referral (see Rapid Review process); recommendation as to how the learning will take place (local v. national)
Rapid Review Report: report is sent to WSCP Children's Exec Lead Officers
Within 20 working days from referral: report sent to National Children's Safeguarding National Review Panel
BLR Meeting: findings and recommendations agreed
Within 28 days of receipt: NCSRSP notify WSCP of decision on Rapid Review
National Child Safeguarding Practice Review (NCSRP led)
Local Child Safeguarding Practice Review (locally led) is commissioned; WSCP Children's Executive to advise on methodology
Learning back into partnership and agencies
Actions agreed, activities and outcomes monitored

## 3. Legal Context:

3.1 The national review framework for children (under 18 years old at the time of the incident) is laid out in **Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children (Department for Education, 2018a).**

3.2 Wigan Safeguarding Children's Partnership believe that the opportunities to learn from cases should be taken wherever they are raised rather than solely at the legal threshold detailed in Chapter 4 (page 85). Therefore, in cases where children perhaps do not meet the criteria for a National Child Safeguarding Practice Review Panel notification that triggers a Rapid Review, engagement with the National Review Panel and possible Local Child Safeguarding Practice Review (as set out in Working Together 2018), the Safeguarding Children's Partnership may still undertake a local Brief Learning Review.

### 3.3 Information Sharing:

Information sharing as part of case review processes is covered in the WSCP Information Sharing Protocol.

## 4. Process for Children & Young People

4.1 This section outlines the process for referring a case into the Safeguarding Children's Partnership for learning regarding children or young people. It starts with the process for identifying and referring serious incidents that fall within the context outlined by Working Together 2018. It sets out some definitions regarding "serious / significant harm" to assist with the decision-making process.

### 4.2 Referring a Potential Case for Learning

4.3 The process for letting the partnership know that a notifiable incident has taken place or simply has learning within it is the same. Practitioners across all agencies are asked to complete a Case Review Referral Form (Appendix One)

4.4 This form will ask whether the practitioner is of the view that the incident is notifiable, and that (from Working Together) serious / significant harm has taken place.

4.5 There are no absolute criteria on which to rely when judging what constitutes serious / significant harm within the domains of physical, sexual, or emotional harm, or that caused by neglect. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, the degree of threat, coercion, sadism, and bizarre or unusual elements.

4.6 In a Health domain harm includes both physical and mental health, and from a 'development' perspective it includes physical, intellectual, emotional, social, and behavioural development.

4.7 To assess whether health or development are being significantly impaired the Children Act 2004 tells us to compare the health or development of the child in question 'with that which could reasonably be expected of a similar child'.

4.8 The definition of harm also includes 'impairment suffered from seeing or hearing the ill-treatment of another".

4.9 It is often difficult to predict the long-term impact of a one-off incident upon a child's future development (e.g., in cases where immediate emergency treatment was required to protect the child's life, but the child has since made an apparent recovery) as only the passage of time will illustrate this. In these circumstances, even if a positive 'physical' prognosis is predicated a notification will be made and a Rapid Review will commence to inform learning.

4.10 The referral criteria for other case review levels can be referred on the same form.

4.11 To ensure that there is a system wide understanding of this process, the partnership will ensure there is a communication plan for all front-line staff across agencies as to how this is undertaken. The referral form is supplied in Appendix One.

**4. 12 Process for Reporting Notifiable incidents to National Child Safeguarding Practice Review Panel**

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

4.14 Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify both OFSTED and the Child Safeguarding Practice Review Panel via the notification system (https://www.gov.uk/guidance/report-a-serious-child-safeguarding-incident) if:

a. The child dies or is seriously harmed in the local authority's area; or
b. While normally resident in the local authority's area, the child dies or is seriously harmed outside England.

4.15 The Wigan Safeguarding Children's Partnership Team discharge this responsibility for the Local Authority. The decision for whether the threshold for notifiable incident has been reached will be made jointly by delegated officers within the tripartite agencies once a Case Review Referral has been sent to the Safeguarding Team, and where one partner agrees criteria has been met, notification will be made. This will then either follow the Working Together Rapid Review process following a notifiable incident, or simply progress as a local Brief Learning Review. The WSCP Independent Scrutineer will be informed of the decision taken.

**4.16 Rapid Reviews**

4.17 In all cases notified to the National Child Safeguarding Practice Review Panel, Wigan Safeguarding Children's Partnership are required to complete a Rapid Review in order to:

- gather the facts about the case, as far as they can be readily established at the time.
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately.

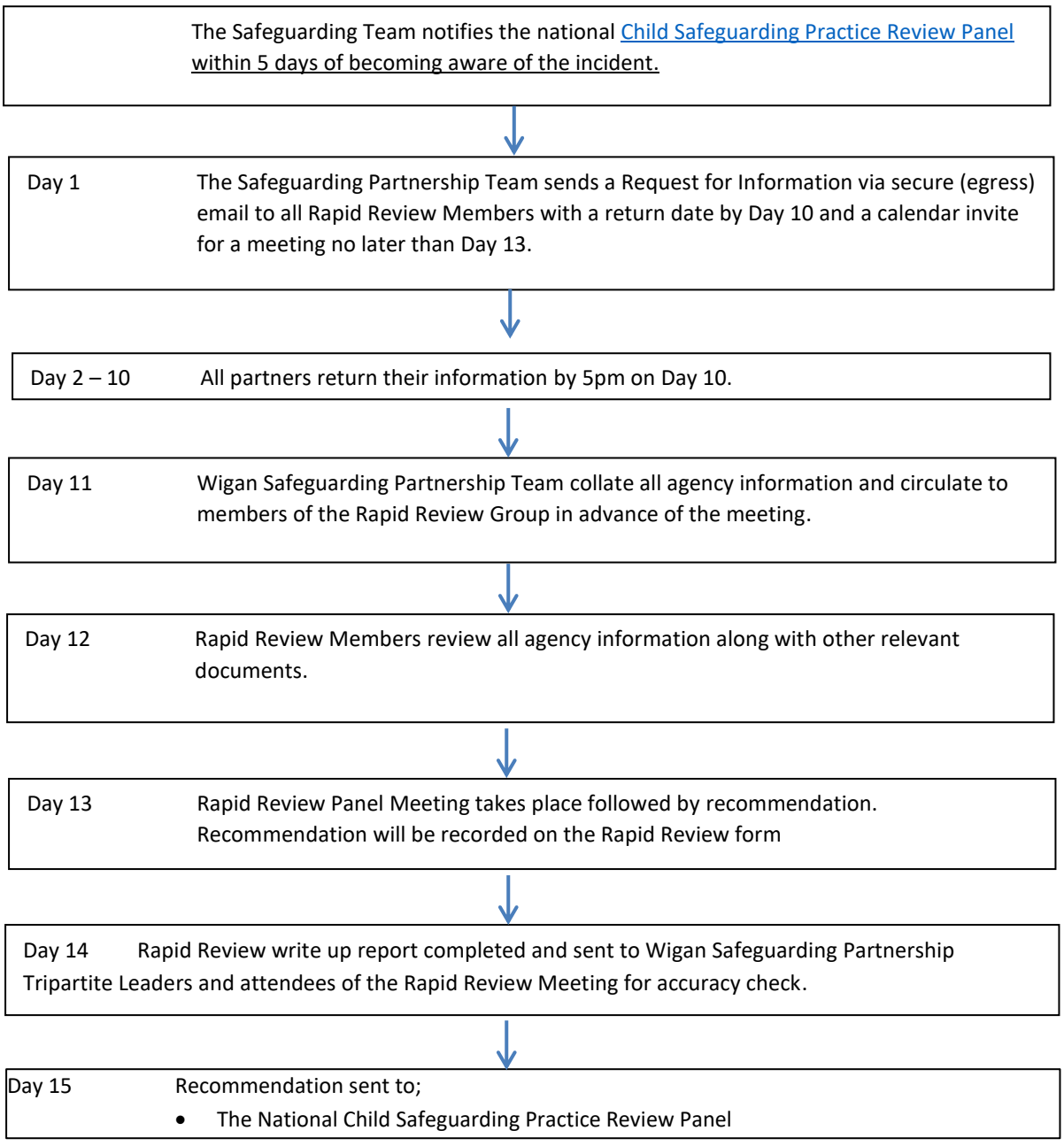
- consider the potential for identifying improvements to safeguard and promote the welfare of children.
- decide what steps they should take next, including whether to undertake a Child Safeguarding Practice Review.

**4.18 Information requests and timeline:**

4.19 All Rapid Reviews must be completed within 15 Days (working days) from notification to comply with Working Together 2018.

4.20 The flowchart below outlines this process:

**Rapid Review Process Flowchart**



**4.21 Recording of recommendation from Rapid Reviews:**

4.22 At the Rapid Review Panel on Day 13 of the Rapid Review Process, the following form will be completed by the Chair on behalf of the panel and submitted, along with the final report to the Tripartite Safeguarding Partnership Leads for sign off. The WSCP Independent Scrutineer will also be informed.

| **Wigan Safeguarding Children's Partnership Rapid Review Recommendation Form :** |
|---|
| Was the recommendation unanimous? **Yes No** ☐<br>**Comments/reasons for dissent/who?** |
| Was the criteria met? *(Please tick all that apply)*<br>Where a local authority in England knows or suspects that a child has been abused or neglected;<br>☐ the child has died or is seriously harmed in the local authority's area; or<br>☐ while normally resident in the local authority's area, the child dies or is seriously harmed outside of England.<br>**Does this case meet the following criteria for a Local Child Safeguarding Practice Review**<br>☐ highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified;<br>☐ highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children;<br>☐ highlights or may highlight concerns regarding two or more agencies working together effectively to safeguard and promote the welfare of children;<br>☐ is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate.<br>**Does this case meet the following criteria for a National Child Safeguarding Practice Review**<br>☐ highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified;<br>☐ raises or may raise issues requiring legislative change or changes to guidance issued under or further to any enactment;<br>☐ highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children.<br>☐ **The Case did not meet the criteria for a National/Local Child Safeguarding Practice Review** |
| ☐ My / our decision is that National / Local (delete as appropriate) Child Safeguarding Practice Review should be undertaken.<br>☐ My / our decision is that this case does not meet the criteria for a National/Local Child Safeguarding Practice Review |
| **Name** (Wigan Safeguarding Children's Partnership Tripartite Leader)<br>**Dated** |

4.23 After completion by the Tripartite Safeguarding Lead the form will be returned to Wigan Safeguarding Children's Partnership Team Business Manager r.bolton@wigan.gov.uk and Business Support Manager wscb@wigan.gov.uk

4.24 The Rapid Review Report and recommendation form will be sent to the National Child Safeguarding Practice Review Panel (Mailbox.NationalReviewPanel@education.gov.uk ) on Day 15 of the process by Wigan Safeguarding Children's Partnership Team.

**4.25 Communication of outcome.**

4.26 The National Child Safeguarding Practice Review Panel (NCSRP) meet on a monthly basis. The commitment from the NCSPRP is to inform the Safeguarding Partnership within 10 days of that meeting. This, theoretically, means that it may be up to a maximum of 4 – 5 weeks before the Safeguarding Partnership is aware of the outcome and can communicate it.

4.27 All decisions will be shared with the attendees of the meeting and also with the tripartite leaders.

**4.28 National Child Safeguarding Practice Reviews:**

4.29 The National Child Safeguarding Practice Review Panel have the discretion to directly commission / undertake a case review. Should this be the case then Wigan Safeguarding Children's Partnership Team will be the conduit between the local partner agencies and the Reviewer/s commissioned by National Child Safeguarding Practice Review Panel.

**4.30 Local Child Safeguarding Practice Reviews; Methods of Review:**

4.31 Local Child Safeguarding Practice Reviews will be administratively facilitated by the Safeguarding Children's Partnership Team on behalf of the Safeguarding Children's Partnership. To facilitate rapid but robust learning, the tripartite leadership will consider all appropriate avenues regarding how best to secure learning. This may entail full Independent Reviewer led panels, but it may wish to consider other key learning regarding the circumstances of a specific incident and draw on this. It may wish to consider other local authority case reviews that cover similar circumstances and incorporate those lessons (that can be identified as specific to Wigan). In some cases, professionals may feel that substantial learning has already been achieved through the rapid review process itself. Each case will require best judgment as to how to proceed to quickly to secure and embed the learning. Each case will be considered by the WSCP Children's Executive and all local child practice review methods will require mandating by the National Review Panel.

4.32 Where an Independent Chair and panel approach has been agreed, Local Child Safeguarding Practice Reviews should be completed via a methodology that supports the systems learning approaches advocated in the Munro report (2011). Independent Reviewers and other reviewers may adopt their own methodology within this scope, but the completed review must include:

- 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.

**4.33 Appointment and terms of Independent Reviewers**

4.34 The tripartite leadership will decide on whether to commission an Independent lead reviewer. Where it is decided by the tripartite leadership that the Local Child Safeguarding Practice Review should be undertaken by a Partnership Independent Reviewer, the tripartite leadership will consider, from the identified partnership reviewers, who's expertise, experience and knowledge is best suited to the themes identified during the Rapid Review Process.

4.35 The Business Manager of the Safeguarding Children's Partnership will approach reviewers to ascertain availability for the work, envisaged costs (in the case of independent lead reviewers) and provide the potential reviewer with an oversight of the outcomes of the Rapid Review.

4.36 A member of the tripartite leadership will confirm the appointment of a reviewer.

4.37 Reviewers will be required to sign an Agreement of Engagement which confirms terms and conditions and timescale of review. Every effort will be made to ensure that the whole Local Child Safeguarding Practice Review Process is completed within 6-8 months. (There may be issues that cause this timeline to be adjusted). In line with national guidance, completed reports should be around 30 pages long. The final report should be suitable for publication.

**4.38 Appointment of Local Child Safeguarding Practice Review Panel**

4.39 A Local Child Safeguarding Practice Review Panel will be formed of the strategic safeguarding leads from the agencies that had been involved with the child and family.

4.40 Panel members will be expected to be independent of having had any previous involvement with the case and to be able to provide objective critical analysis of their agencies involvement. Panel members will provide the link between the Local Child Safeguarding Practice Review Panel and their own agency senior management.

**4.41 Practitioner involvement in Local Child Safeguarding Practice Reviews:**

4.42 As part of most Local Child Safeguarding Practice Reviews there will be Practitioner Learning events. The LCSPR panel will be responsible for informing the Safeguarding Children's Partnership Team of which practitioners either directly involved in the case being reviewed, or representative of that role are appropriate to attend.

4.43 The LCSPR representative for an agency will be responsible for any preparatory conversations with practitioners who will be attending LCSPR Practitioner Learning Events and in supporting them after the event has taken place.

4.44 Wherever possible the LSCPR representatives should take steps to ensure that practitioners are involved in all stages of the case review process including attendance at panel meetings, again ensuring preparatory conversations have taken place and there is opportunity for de-brief and support following the meeting.

4.45 Family and where possible the individual subject to review, should be informed of the review process at the earliest opportunity. LSCPR representatives should actively seek the means to involve individuals and their families throughout the review process. This should be tailored based on their needs and wishes. Representatives should prevent and remove barriers to involvement. LSCPR representatives should ensure that individuals and their families receive a

robust offer of support throughout the process, which allows individuals and families to feel empowered and informed by the review process.

**4.46 Family / Individual Involvement:**

4.47 The views of the individual who is subject of the review and their family will always aim to be sought. The stage of the LCSPR at which this takes place will be considered specifically by the LCSPR panel and independent reviewer if in place. Any ongoing communication with family members or individuals about the progress of a review will be sensitively managed and a priority for the partnership.

**4.48 Requests for Information:**

4.49 Through the review the LCSPR Panel and Independent Reviewer will be requested to provide information related to the case or their service. It is important that agencies adhere to timescales for requests, providing either a response to the request or an update on progress before the agreed deadline. Returns submitted to the review process should be of high quality. Agencies should focus on the key learning outcomes for their own agency and include only information. Good quality returns examples can be provided by the Safeguarding Partnership Team on request.

**4.50 Draft Reports and presentation of report to the Safeguarding Partnership:**

4.51 Throughout the review process the Independent Reviewer / Lead Reviewer will circulate draft versions of reports via the Safeguarding Children's Partnership Team. These will be sent securely to the LCSPR Panel and must not be forwarded to anyone else without permission of the Independent Reviewer. These drafts must be destroyed / deleted at the end of the review process.

4.52 The final draft of the review will be circulated for factual accuracy checks only to the LCSPR Panel. Thereafter the report will be presented to the next scheduled Wigan Safeguarding Children's Partnership Leadership Meeting by the Independent Reviewer.

**4.53 Publication:**

4.54 Issues concerning publication of Local Child Safeguarding Practice Reviews are given detailed guidance in Chapter 4 of Sections 37 – 41 of Working Together 2018. Reports should be "written in such a way so that what is published avoids harming the welfare of any children or vulnerable adults involved in the case" (S39, Chapter 4 Working Together 2018).

4.55 After receiving the completed LCSPR report, the Safeguarding Children's Partnership Team will send a copy of the report to the National Child Safeguarding Practice Review Panel and to Ofsted.

4.56 A decision will be made by the tripartite partnership leaders on whether to publish the full report or report on the improvements to be made following the review. This decision must be recorded by the Tripartite Partnership Leaders, specifically through discussion and agreement at the Children's Executive Group. Should the decision be to not publish either the full overview report or the improvements to be made then the Tripartite Partnership Leaders must write to the National Child Safeguarding Practice Review Panel with the rationale. Published reviews and improvement plans will remain on the WCSP website for one year and on the National Safeguarding Review Panel Repository thereafter.

## 5. Learning and Improvement in the Local Child Safeguarding Practice Review Cycle:

5.1 Working Together 2018 places a responsibility on the Safeguarding Children's Partnership to identify learning and respond to it throughout the process of the review. Learning should be extracted and actioned at the earliest opportunity.

5.2 The Partnership Learning and Improvement officers will attend all panel meetings to understand themes and early learning opportunities from cases. The Learning and Improvement officers will also record and track actions from each meeting. Theme specific learning products may be developed and disseminated to the wider workforces while review processes are on-going. On completion of the review process, a 7-minute briefing will be produced based on whole case learning. This will be published on the WSCP website and disseminated to the case review panel members and Partners Improving Practice panel members for further dissemination to the workforce.

5.3 Action plans for each case will be developed based on the recommendations of the review. The partnership will work directly with case review panel members and representatives from relevant agencies to break down recommendations into agency specific actions. Action completion will be tracked and monitored by the Learning and Improvement officers and reported on through the Case Review Sub-Group. Agencies should seek to assure the Partnership team that learning is becoming embedded in practice. Agencies should share the timetables/findings of single agency audit work, or other means of evidencing this with the Learning and Improvement officers. Partners should work with the partnership team to develop and close the learning cycle in relation to each case. The learning and improvement officers will support partners to measure the impact f reviews through auditing practice.

**5.4 Parallel Learning processes:**

5.5 In many cases the Local Child Safeguarding Practice Review will be running simultaneously with other defined learning process including:

- National Health Service Improvement processes such as the Strategic Executive Information System process (StEIS) and in cases where a case meets the definition of a patient safety incident it will also be subject to National Learning and Reporting System (NLRS).
- Independent Office of Police Conduct.
- Greater Manchester Fire and Rescue Service serious incident review.
- National Probation Service Serious Incident Review process.
- Mental Health Homicide Review.
- MAPPA Serious Case Review
- LeDeR Review.
- Domestic Homicide Review.

5.6 The concurrent running of these processes will be discussed in LCSPR Panel meetings with the expectation of agencies connected to the processes sharing and emerging learning into the LCSPR Process. The Safeguarding Children's Partnership Learning and Improvement officers will build this into the ongoing Action Plan for that LCSPR.

5.7 Where possible and/or appropriate, the partnership may consider combining review processes. This will be the initial decision of the Children's Executive Group and may require permission from national oversight panels such as the Children's National Review Panel.

5.8 During the LCSPR cycle, where any agency develops an action plan, undertakes any quality assurance work, audit, review activity or change to procedures in relation to an incident that triggered a LCSPR then the outcome of this will be shared with the LCSPR Panel and Independent Reviewer.

5.9 Throughout the review process the WSCP Learning and Improvement officers will attend panel meetings and practitioner events

**5.10 Police Investigations:**

5.11 Some LCSPR's will be being undertaken whilst there is an ongoing criminal investigation. The main point of contact between the LCSPR Panel and Independent Reviewer will be maintained between the Safeguarding Children's Partnership Team and Greater Manchester Police's Serious Case Review Team.

**5.12 Coronial Processes:**

5.13 The Brief Learning Review, Local Child Safeguarding Practice Review cycles may run in parallel to Coroners investigations into a death.

5.14 The Safeguarding Children's Partnership Team will inform HM Senior Coroner for Greater Manchester West, of all cases where a Local (or National) Child Safeguarding Practice Review is to be conducted on a case that is awaiting inquest. If requested, the report from review processes will be shared with the coroner.

5.15 Whenever a Coroner issues a Prevention of Future Deaths Report (Regulation 28 Coroners Act 2009) to one of the Safeguarding Partners, that partner organisation will inform the Safeguarding Children's Partnership Team, of the report and of their response to the Coroner. This will then be discussed at a future Safeguarding Children's Partnership Leadership meeting.

**5.16 Professional Registration body notification:**

5.17 Where any Rapid Review, Brief Learning Review, LCSPR identifies issues around a member of the workforce that may meet criteria for notification to a registrant body e.g., Royal College of Nursing, Health and Care Professions Council, Social Work England, IOPC, General Medical Council then the Partnership Leader for their employing organisation will have responsibility for ensuring that appropriate notifications are made.

## 6. Brief Learning Reviews (BLR'S)

6.1 A Brief Learning Review is a learning process that takes after the requirements and consideration for Rapid Review for children's cases have taken place. Depending on the nature of the referral it may be a case that could be described as a "near miss", contain an element of learning that the practitioner considers crucial to system wide multi agency learning. It may be a positive case where practitioners either singly or in partnership have achieved outstanding outcomes for the individual being supported.

6.2 The aims of a Brief Learning Review are:

(i) Ensure there is a coordinated and multi-agency response for the rapid identification of responses needed to safeguard others following serious safeguarding concerns.

(ii) Identify early learning and develop actions for improvement for Wigan Safeguarding Children's Partnership.

6.3 A Brief Learning Review will be undertaken on the following cases (for example):

- Any case where it is thought that a person has potentially died because of their own actions.
- When an agency identifies that there may be wider system learning from an active, or closed case.
- When an agency feels that there is benefit in sharing the effective multi-agency practice around a case so that the factors that have influenced this success can be identified and shared back into workforce development.

**6.4 Referral Process for Brief Learning Review**

6.5 To generate a brief learning review, the practitioner simply needs to fill in the generic Case Review Referral form and send to wscb@wigan.gov.uk

6.6 When the Safeguarding Children's Partnership Team have received the notification:

- An email will be sent to all Children's Safeguarding SPOC's using the secure email system enquiring whether they have known the subject / subjects in the last 12 months.

- This will be followed, if relevant, by a 2nd email inviting the Children's Safeguarding SPOC or relevant agency representative to the BLR meeting, provide contextual detail of why the BLR is being requested and will include a request for information Proforma. This only requires information from the last 12 months of involvement.

6.7 There will be a minimum of 15 working days between the request for information and the BLR meeting, with all information requests being returned by end of Day 13.

**6.8 Brief Learning Review Meetings and outcomes:**

6.9 Brief Learning Review meetings will be chaired by a manager from the Safeguarding Children's Partnership Team and will be scheduled to last 2 hours.

6.10 The meeting includes:

- Sharing of information to construct shared understanding of different agencies involvements / interactions with the subject.
- Opportunity for agencies to question / contextualise any points raised.
- Identification of key themes, main issues and any apparent learning points.
- Consideration of actions.

6.11 However, as a Brief Learning Review is a dynamic learning process the meeting will also explore issues iteratively using various reflective practice 'reflection-on-action' models (Kolb 4 stage model, Gibbs, Schon).

**6.12 Follow up meetings / Action tracking:**

6.13 The aim of a Brief Learning Review is, wherever possible, to complete the learning process in the single meeting and set actions. Actions agreed will be tracked 'virtually' by the Safeguarding Children's Partnership Learning and Improvement officers in line with the timescales set. Progress updates on actions set are expected to be returned 3 weeks following the date of the meeting.

6.14 A BLR may require a follow up meeting, for example of practitioners that were involved in a case, or after parallel processes like Coroners or Health organisation investigations (e.g., STEIS) have concluded, this will be discussed and agreed by meeting attendees.

**6.15 Implementing learning from Brief Learning Reviews:**

6.16 Learning messages from Brief Learning Reviews will be shared in anonymised form with the most relevant appropriate Strategic Partnership Group relevant to the thematic learning from that BLR. Should there not be a Strategic Partnership Group aligned to the learning from that BLR then the Safeguarding Partnership Team on behalf of the Wigan Safeguarding Children's Partnership will convene a meeting of strategic leads for that purpose.

**Appendix One – Case Review Referral Form**

# Case Review Referral Request Form

## Returned by: ……

## Agency: ……

This Case Review Referral is:

- For practitioners in Children's Services.
- To ensure there is a coordinated and multi-agency response for the rapid identification of responses needed to safeguard others following serious safeguarding concerns.
- To act as a referral mechanism for notifiable incidents under Working Together 2018 and whether threshold for referral to National Child Safeguarding Practice Review Panel is met.
- To identify early learning for improvement for partners of Wigan Safeguarding Children's Partnership
- To begin the process of the Brief Learning Review process.

| **Persons Details:** | |
|---|---|
| **Name** | |
| **Alias** | |
| **Date of Birth** | |
| **Address** | |
| **Ethnic Origin** | |
| **Date of Death** | |
| **Date(s) known to Service** | |
| **Significant others: (copy and paste box as necessary)** | |
| **Name** | |
| **Date of Birth** | |
| **Relationship** | |
| **Address** | |
| **Ethnic Origin** | |
| **Significant others:** | |
| **Name** | |

| | |
|---|---|
| **Date of Birth** | |
| **Relationship** | |
| **Address** | |
| **Ethnic Origin** | |

| |
|---|
| **A brief history of the subject of the review – to enable the panel to get a sense of the child / young person or family.** |
| |
| **Please provide details of concerns:** |
| |
| **Please provide brief details of YOUR agency's involvement including names, roles and contact details of key people involved.** (Please indicate who you would consider important to attend the case review) |
| |
| **Please provide brief details of OTHER agencies involvement including names, roles and contact details of key people involved.** (Please indicate who you would consider important to attend the case review) |
| |
| **Please provide identified areas of concern / positive practice on which the case review should focus.** |
| |
| **Please identify any immediate agency actions.** |
| |
| **In the referrers view does the case reach threshold for National Child Safeguarding Practice Review Panel Notification / Rapid Review under Working Together definitions** |
| You may wish to confer with processes within your management line regarding this box. |

| | |
|---|---|
| **Name** | |
| **Role** | |
| **Agency** | |
| **Contact No.** | |
| **Date** | |