Local Child Safeguarding Practice Review (LCSPR) - Process, Roles & Responsibilities

Purpose of an LCSPR is to support learning and improvement when a child has suffered serious harm or has died, where abuse or neglect is known or suspected

1. Identify & Notify

What happens
- A serious incident occurs (death or serious harm).
- Initial safeguarding actions take priority.
- Incident is notified to the Safeguarding Children Partnership – OSCP.group@oldham.gov.uk

Who is responsible
- Practitioners / Managers:
  - Identify serious incidents
  - Inform senior managers and safeguarding leads
- Safeguarding Partnership Business Unit:
  - Log notification
  - Start initial screening via virtual panel, CSC, Police and Health Safeguarding Leads

2. Rapid Review/Screening

What happens
- Information gathered quickly from agencies.
- Decision made on whether criteria for an LCSPR are met.

Key questions
- Was serious abuse or neglect known or suspected?
- Is there multi-agency learning?
- Would a review improve practice?

Who is responsible
- Multi agency senior level panel
- Panel Chair / Statutory Partners
- Agency safeguarding leads (provide timely information)

3. Decision & Scope

What happens
- Decision made to:
  - Undertake an LCSPR, or
  - Use an alternative learning method
- Scope and key learning questions agreed.

Who is responsible
- Multi agency senior level panel
- Business Unit (documentation and coordination)

4. Review Planning

What happens
- Lead reviewer appointed (independent or internal).
- Methodology agreed (e.g. systems-based, learning-focused).
- Timescales, agencies involved, and family engagement approach confirmed.

Who is responsible
- LCSPR Panel, made up of multi agency senior level safeguarding leads
- Lead Reviewer
- Business Unit (project management)

5. Information Gathering & Analysis

What happens
- Agencies submit information and engage in learning activities.
- Front line practitioners may take part in:
  - Reflective practitioner events
  - Case discussions

Key principles
- Learning not blame
- Respectful challenge
- Practitioner voice valued

Who is responsible
- Front line Practitioners: honest reflection and participation
- Agency safeguarding leads: quality assurance of submissions
- Reviewer: analysis and learning identification

6. Family Engagement

What happens
- Family are offered opportunities to:
  - Share their views
  - Understand the process
- Communication is sensitive, timely and clear.

Who is responsible
- Lead Reviewer
- Named Family Liaison (agreed locally)
- Business Unit (coordination and records)

7. Learning Report & Recommendations

What happens
- Report focuses on:
  - What happened
  - Why it happened
  - What needs to improve
- Clear, actionable learning identified.

Who is responsible
- Lead Reviewer (draft report)
- LCSPR Panel (challenge and assurance)
- Strategic Safeguarding Parnters (Final endorsement)

8. Publication & Sharing Learning

What happens
- Report published (with confidentiality protected).
- Findings shared locally and nationally.

Who is responsible
- Safeguarding Partners
- Business Unit
- National Panel (notifications and oversight)

9. Improvement & Impact

What happens
- Learning translated into dissemination of learning :
  - Action plans
  - Workforce development
  - Policy or practice change
  - 7MB
- Impact monitored and reviewed.

Who is responsible
- All Partner agencies involved in the case
- Safeguarding review and learning hub subgroup (oversight and impact)

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