Bath & North East Somerset Community Safety and Safeguarding Partnership

Notifiable Incidents, Child Safeguarding Practice Reviews and Rapid Review Procedures

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Author:	Kirstie Webb
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1. Overview

1.1 The amended Working Together to Safeguard Children 2018 (WT2018) guidance was published following consultation in 2017 to establish the changes needed in light of the new Children and Social Work Act 2017.

1.2 The key changes that have taken place that influence this review process are;

- **1.2.1** Replacement of Local Safeguarding Children's Boards with Safeguarding Partners (Hereafter referred to as the Partnership)
- **1.2.2** Serious Case Reviews have been replaced by a system of national and local child safeguarding practice reviews (CSPR)
- **1.2.3** The responsibility for child death reviews has transferred to the new Child Death Review Partners

1.3 The Working Together: transitional guidance Working Together: transitional guidance sets out statutory guidance for Local Safeguarding Children Boards, local authorities, safeguarding partners, child death review partners and the Child Safeguarding Practice Review Panel.

1.4 The transitional guidance applies across England from the 29th June 2018 and expires on the 29th September 2020.

1.5 New safeguarding partner and child death review partner arrangements must be established by the 29th September 2019.

1.6 After the 29th September 2019, LSCBs in the area have a statutory 'grace' period of up to 12 months to complete and publish outstanding SCRs and up to four months to complete outstanding child death reviews.

1.7 The Child Safeguarding Practice Review Panel (hereafter referred to as the 'Panel') was established on the 29th June 2018 in readiness for the enactment of WT2018. Since then, local authorities are required under a new statutory duty, to notify the Panel of incidents where they know or suspect that a child has been abused or neglected and the child has died or been seriously harmed.

1.8 The Panel will consider any serious child safeguarding case at a Panel meeting in order to decide whether it meets the criteria for a national CSPR.

2. Purpose of child safeguarding practice reviews

2.1 The purpose of reviews of serious child safeguarding cases is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but may have wider importance to continuous improvement.

2.2 Reviews must seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account.

3. Notifiable Incidents

3.1 WT2018 identifies serious child safeguarding cases as those which:

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

3.2 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. This is not an exhaustive list. When making decisions, judgment 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.

3.3 The Partnership use an online hosting system (QES) to make notifications and manage the information required for Child Safeguarding Practice Reviews. A notification can be submitted to the Partnership through New notification. Guidance for completing the notification can be found here Notification guidance.

3.4 Upon the completion of a serious incident notification, the Partnership Business Unit will receive electronic notification and will inform the Independent Chair and the Partnership Practice Review Sub-group (PRG) Chair. They will schedule an extra-ordinary meeting of the PRG within ten working days of notification. This may be done virtually with representatives of the five statutory agencies, (local authority, CCG, Police, Probation and Fire & Rescue Service due to time constraints).

3.5 There is a duty on the local authority to notify incidents to the Child Safeguarding Practice Review Panel under section 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) which states:

Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel 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.

3.6 The local authority must notify any event that meets the above criteria to the Panel. They must do so within five working days of becoming aware that the incident has occurred. The local authority must also report the event to the safeguarding partners in their area, and other areas if appropriate, within five working days.

3.7 The local authority must also notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected.

3.8 The duty to notify events to the Panel sits with the local authority. Others who have functions relating to children should inform the Partnership of any incident which they think should be considered for a child safeguarding practice review. Contact details and notification forms for local authorities to notify incidents to the Panel can be found on the 'report a serious child safeguarding incident page on Gov.uk.

4. The Rapid Review

4.1 When the serious incident notification is received by the Partnerships Business Unit, an email will be circulated to all relevant organisations / agencies requesting information across an agreed timeline.

4.2 The members of the Partnerships Practice Review Sub-group (PRG) will promptly use this information to undertake a rapid review of the incident, in line with any guidance published by the Panel. The rapid review will enable the PRG 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 or not to undertake a child safeguarding practice review

4.3 The rapid review must record:

- immediate safeguarding arrangements of any children involved
- a concise summary of the facts, so far as they can be ascertained, about the serious incident and relevant context; this should give sufficient detail to underpin the analysis against the Working Together criteria, but does not require lengthy detailed chronologies of agency involvement that can obscure the pertinent facts
- a clear decision as to whether the criteria for a local CSPR have been met and on what grounds, and if not, why not. Clear reasons are required

- a recommendation on whether or not a national review would be considered necessary, and if so, why. Clear reasons are required
- any immediate learning already established and plans for dissemination
- potential for additional learning
- if the decision is taken not to proceed with a local CSPR, a summary of why it is thought there is no further learning to be gained
- which agencies have been involved in the rapid review, explaining any agency omission whose involvement would usually be expected
- relevant identifying details of the child and family

4.4 Upon completion of the rapid review by the PRG and within 10 working days of the notification, the report, including recommendations, will be sent to the Partnerships Executive Group for ratification.

4.5 If there is discrepancy between the decision of the PRG and that of the Executive Group, the Executive Group must provide a rationale for their decision which must be sent to the National Panel within 15 working days of notification of the incident.

4.6 Once ratified by Executive Group, which must be within 15 days of notification of the serious incident, the Partnership Business Unit will send a copy to the Panel. They will share with the Panel their decision about whether a local child safeguarding practice review is appropriate. They will also notify the Panel, if during the course of a local child safeguarding practice review, new information comes to light that suggests a national review may be appropriate.

4.7 If it is agreed that a local review will be carried out, the Partnership Business Unit will inform the Panel, Ofsted and DfE, including the name of the commissioned reviewer.

5. Decisions on local and national reviews

5.1 The Partnership must make arrangements to:

- Identify serious child safeguarding cases which raise issues of importance in relation to the area; and
- Commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

5.2 When a serious incident becomes known to the Partnership, they must consider whether the case meets the criteria for a local review.

5.3 Meeting the criteria does not mean that the safeguarding Partnership must automatically carry out a local child safeguarding practice review. They must determine whether a review is appropriate, considering that the overall purpose of a review is to identify improvements to future practice. Decisions on whether

to undertake a review should be transparent and the rationale communicated appropriately, including to families.

5.4 WT2018 states that the Partnership must consider the following criteria and guidance when determining whether to carry out a local child safeguarding practice review:

- 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

5.5 WT2018 states that the Partnership should have regard to the following circumstance:

- 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

5.6 Some cases may not meet the definition of a 'serious child safeguarding case', but raise issues of importance to the local area. For example, where there has been good practice, poor practice, or 'near miss' events. The Partnership may choose to undertake a local CSPR in these or other circumstances.

6. Local child safeguarding practice reviews

6.1 The Partnership is responsible for commissioning and supervising reviewers for local reviews

6.2 In all cases, they will consider that the reviewer has the following:

- 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
- whether the reviewer has any real or perceived conflict of interest

6.3 The Partnership will agree with the reviewer, the method by which the review will be conducted, taking into account WT2018 guidance and the principles of the systems methodology recommended by the Munro review. Assets Publishing Munro Review

6.4 The agreed methodology will provide a way of analysing frontline practice as well as organisational structures and learning. The review will reach recommendations that improve outcomes for children, reflect the child's perspective and the family context.

6.5 The review will be proportionate to the circumstances of the case, focus on learning, establish and explain the reasons why the events occurred as they did.

6.6 To ensure quality, the Partnership will ensure:

- practitioners are fully involved in reviews and invited to contribute their perspectives
- families, including surviving children, are invited to contribute to reviews. This is vital 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 will be managed appropriately and sensitively.

6.7 The Partnership will supervise the review to ensure satisfactory progress is being made and the review is of satisfactory quality. Any request for information made by the Partnership to the reviewer will be done in writing.

7. Publication of local child safeguarding practice reviews

7.1 The Partnership will ensure 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.

7.2 Recommendations will be clear on what is required of relevant agencies and others collectively and individually, by when and will focus on improving outcomes for children

7.3 In the interests of sharing learning and improvement, the Partnership will publish the final report, unless they consider it inappropriate to do so. In such circumstance, the Partnership will publish information about the improvements that should be made that they consider appropriate to publish. The name of the reviewer will be included. The published report or information will be publicly available for one year.

7.4 Reports and recommendations will be signed off by the Partnerships Executive Group.

7.5 Reports, recommendations and decisions will be scrutinised by the Independent Chair of the Partnership.

7.6 The Partnership will consider carefully how best to manage the impact of the publication on children, family members, practitioners and others closely affected by the case. The partnership will ensure that reports are written in such a way that what is published avoids harming the welfare of any children or vulnerable adults involved in the case.

7.7 The Partnership will send a copy of the full report to the Panel, the Secretary of State and Ofsted no later than seven working days prior to the date of publication. If only information related to improvements is being published, then the partnership will provide a copy of that to the Panel, Secretary of State and Ofsted within the same timescale.

7.8 Depending upon the nature and complexity of the case, the report will be completed and published as soon as possible and no later than six months from the date of decision to initiate a review. Where other proceedings have an impact or delay publication, for example an ongoing criminal investigation, the Partnership will inform the Panel and Secretary of State.

7.9 The Partnership will set out for the Panel and the Secretary of State the justification for any decision not to publish either the full report or information relating to improvements. It is a requirement that the Partnership have due regard to any comments that the Panel or the Secretary of State may make in respect of publication.

7.10 The Partnership will make every effort, both before the review and during, to capture points from the case about improvements needed, take corrective action and disseminate learning.

8. The National Panel

8.1 On receipt of information form the rapid review, the Panel must decide whether it is appropriate to commission a national review of a case or cases.

8.2 The criteria which the Panel must take into account include 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
- 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

8.3 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
- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings

8.4 In addition to considering notifications from local authorities and information from rapid reviews and local child safeguarding practice reviews, the Panel will take into account a range of other evidence, including inspection reports, other reports and research. The Panel can take into account any other criteria they consider appropriate to identify whether a serious child safeguarding case raises issues which are complex or of national importance.

8.5 The Panel will inform the Partnership promptly following receipt of the rapid review, if they consider that:

- a national review is appropriate. They must set out the rationale for their decision and the next steps
- further information is required to support the Panel's decision –making

8.6 The Panel will take decisions on whether to undertake national reviews and communicate their rationale appropriately, including to families. They must also notify the Secretary of State.

8.7 If the panel decides to undertake a national review, they will discuss with the Partnership the potential scope and methodology of the review and how they will engage with them and those involved in the case.

8.8 Alongside a local or national review, there may be a criminal investigation, coroner's investigation and/or professional body disciplinary procedures. The Panel and Partnership must have clear processes for how they will work with other investigations, including Domestic Homicide Reviews, multi-agency public protection arrangement reviews or Safeguarding Adult Reviews and work collaboratively with those responsible for carrying them out.

9. Parallel Processes

9.1 It may occur that a CSPR is being conducted in parallel with criminal, civil or regulatory investigations or human resources procedures. Other reviews may

also be being conducted at the same time, such as domestic homicide reviews, mental health independent investigations and safeguarding adult reviews. When a child has died there will be a coroner's inquest. There may be family court proceedings in relation to surviving children.

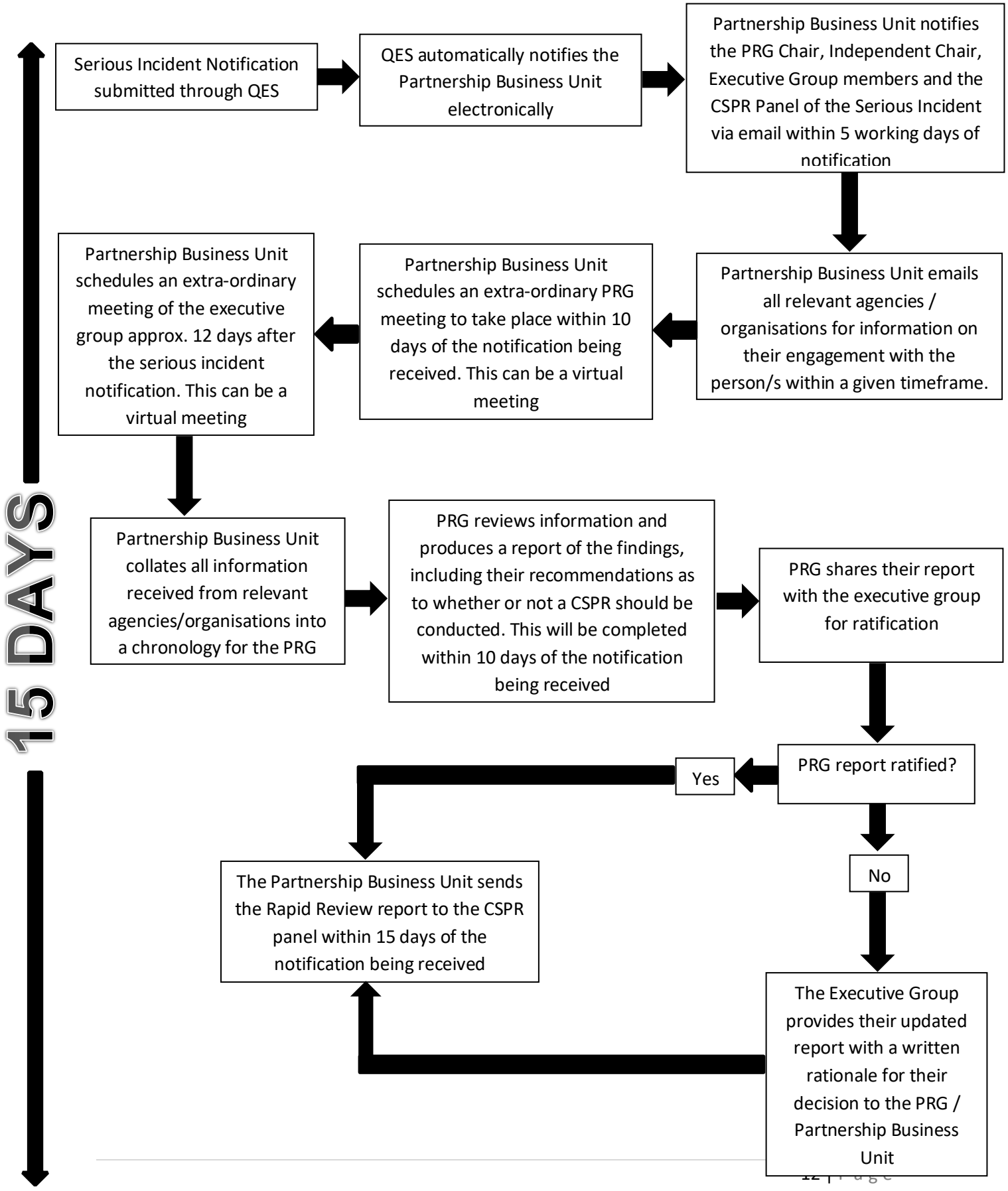
9.2 All reviews and investigations have distinct purposes and are subject to their own statutory guidance. These processes are no always mutually compatible. No process has more importance, so none automatically take precedence, however, judges in civil and criminal proceedings may make orders that impact on the local CSPR.

9.3 Where there are parallel processes, the local CSPR will be managed to avoid duplication of effort, prejudice to criminal trials, unnecessary delay and confusion for staff and families.

9.4 The PRG will ensure that where parallel processes have been identified:

- due consideration is given to parallel processes in the terms of reference/scoping phase
- where necessary, early discussions take place between the police / Crown Prosecution Service and the Partnership
- there is correspondence between all relevant reviews to achieve best fit for circumstance
- the final CSPR acknowledges any interaction with other reviews and their impact on the CSPR.
- ADCS Protocol and Good Practice Model 2013

Appendix 1 – Serious Incident Notification Rapid Review Process



Appendix 2 – Local Child Safeguarding Practice Review Process