LSCB

Bath & North East Somerset
Local Safeguarding Children Board

Notifiable Incidents, Serious Case Review and Other Multi-Agency Review Procedures

Date approved by LSCB	December 2015 Amended September 2016 and March 2017 Amended February 2019
Author	Original Author: Julie Downey Review Author: Suzanne Cheng and Leigh Zywek
Date for review	December 2019 to update with new safeguarding arrangements
Detail of review amendments September 2016 February 2019	 Change to Secure email address Changes to online notification process and WT2018 transition processes

Contents **Page**

Appendices

1. Introduction

1.1 This Procedure has been revised in line with the changes made to the Serious Case Review Process as outlined in Working Together to Safeguard Children 2015 (WT2015) by the introduction of Working Together 2018. The Process also includes what to do with notifiable incidents. Note this process does not replace the role of the Child Death Overview Panel as outlined in chapter 5 of WT2015.

1.2 The Child Safeguarding Practice Review Panel (Hereafter referred to as "Panel") has been set up since 29th June 2018 in readiness for the enactment of Working Together 2018. From 29 June 2018, 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.

From 29 June 2018, local authority areas must begin their transition from LSCBs to safeguarding partner and child death review partner arrangements. The transition must be completed by 29 September 2019.

The Panel will consider any serious child safeguarding case at a future Panel meeting in order to decide whether it meets the criteria for a national child safeguarding practice review. As set out in Working Together: Transitional Guidance, LSCBs are required to provide rapid reviews of serious safeguarding cases to the Panel. As quoted from the transitional guidance, the aim of a rapid review is 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 an SCR

The rapid review should include your decision about whether an SCR is appropriate and whether you believe the case may raise issues which are complex or of national importance such that a national review may be appropriate.

LSCBs must only commission SCRs until the point at which safeguarding partner arrangements begin to operate in a local area. LSCBs should only use the SCR criteria set out in Working Together 2015.

This procedure covers both periods when the LSCB is operating in it's current format under Working Together 2015, as well as the forthcoming Safeguarding Partnership arrangements as outlined in Working Together 2018. The following sections provide details for both sets of arrangements, Option A refers to the current LSCB and Working Together 2015 requirements, Option B refers to the new Safeguarding Partnership arrangements and Working Together 2018. As the LSCB transitions to the new Safeguarding Partnership arrangements, there may be a "grace period" where a Serious Case Review that has already commenced needs to continue to be managed by the LSCB until dissolution.

'Grace' period

Some SCRs may not have been completed and/or published at the point that the new safeguarding partner arrangements begin to operate in all areas covered by the LSCB. Where this is the case, the transitional arrangements allow LSCBs to continue for a 'grace period' of **a maximum of 12 additional months** from that point to complete and publish these SCRs.

During the grace period, LSCBs may not commission new SCRs, even if the incident occurred before the start of the grace period, or carry out any other former functions. Information relating to any incidents where decisions on SCRs have not been taken should be passed to the safeguarding partners.

They should also pass on to safeguarding partners any information relating to learning arising from such SCRs (including where these are still in progress), so that the safeguarding partners can consider follow-up actions as appropriate.

If an SCR is not completed or not published by the end of the grace period, the LSCB must pass the complete but unpublished SCR or where it has not been completed, all information relating to the review (which should include learning arising from it), to the safeguarding partners, the Child Safeguarding Practice Review Panel and the DfE.

2A Criteria for Notifiable Incident and SCR managed by LSCBs under Working Together 2015

2.1 A **Notifiable Incident** as set out in WT2015 is as follows:

An incident involving the care of a child which meets <u>any</u> of the following criteria:

- *A child has died (including cases of suspected suicide), and abuse or neglect is known or suspected;*
- *A child has been seriously harmed and abuse or neglect is known or suspected;*

- *A looked after child has died (including cases where abuse or neglect is **not** known or suspected); or*
- *A child in a regulated setting or service has died (including cases where abuse or neglect is **not** known or suspected).' (p74 WT2015)*

2.2 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCB's. This includes the requirement for LSCB's to undertake reviews of serious cases and advise on lessons to be learned in specified circumstances, namely:

'5 (2) For the purpose of paragraph (1) a serious case is one where:

*(a) abuse or neglect of a child is known or suspected: **and***

(b) either – (i) the child has died; or
(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority their Board partners or other relevant persons have worked together' (p75 WT2015)

2.3 WT2015 guidance clarifies the term "seriously harmed" for which the definition now reads as:

- *A potentially life threatening injury;*
- *Serious and/or likely long term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.*

This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred. The LSCB should ensure that their considerations on whether serious harm has occurred are informed by research evidence.

*Cases which meet one of the criteria (i.e. regulation 5(2)(a) and (b)(i) or 5 (2)(a) and (b)(ii) **must always** trigger an SCR. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide. Where a case is being considered under regulation 5(2)(b)(ii) unless there is definitive evidence that there are no concerns about inter agency working the LSCB **must** commission an SCR.*

*In addition, even if one of the criteria is not met, an SCR **should always** be carried out when a child dies in custody, police custody, on remand or following sentencing, in a Young Offenders Institution, or in a secure children's home. The same applies where a child dies who was detained under the Mental Health Act 1983 or where a child aged 16 or 17 years was the subject of a deprivation or liberty order under the Mental Capacity Act 2005.* (p76 WT2015)

2B Criteria for Notifiable Incident and Serious Safeguarding Cases managed by Safeguarding Partnership Arrangement under Working Together 2018

Serious child safeguarding cases are 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 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.

Safeguarding Practice Review Panel 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) 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

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

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.

The duty to notify events to the Panel rests with the local authority. Others who have functions relating to children should inform the safeguarding partners of any incident which they think should be considered for a child safeguarding practice review. Notifications are made online via https://childsafeguarding.education.gov.uk/

3A. What to do if the Criteria for Notifiable Incident is met when managed by LSCBs under Working Together 2015

3.1 While the LSCB remains in existence in the local area, the local authority should report to the LSCB any child safeguarding incidents which they are notifying to the National Panel using the new online process https://childsafeguarding.education.gov.uk/ . They should do this within **five working days** of becoming aware that the incident has occurred.

3.2 Note the guidance is clear that if an incident meets the criteria for a Serious Case Review (see 2.2) *then it will also meet the criteria for a notifiable incident*. *There will, however, be notifiable incidents that do not proceed through to Serious Case Review.* (p75 WT2015)

If it meets the criteria the SCR Sub Group will undertake:-

- **Rapid review for every notification**
- **Local safeguarding practice review where appropriate**

The Rapid Review has to be conducted and the outcomes returned to the National Panel within 15 working days of becoming aware of the incident.

The National Panel will then respond to the report recived stating whether or not they agree with the recommendation made by the SCR Sub Group

4A. How to Initiate a SCR and the Decision Making Process for the LSCB under Working Together 2015

4.1 The LSCB for the area in which the child is normally resident must decide whether an incident notified to them by lead agencies meets the criteria for a SCR.

4.2 Where an agency believes the SCR criteria has been met they must submit a notification via the link:
https://www.gesonline.com/BATHNES/ECR/Live/m/ecr/public/newnotification

Guidance for completing a notification or submitting requested information is available: SCR/SAR Guidance

4.3 Upon receipt of the notification the Chair of the LSCB SCR sub group will contact to all agencies named in the notification to gather information about their involvement with the child to help inform the sub group discussion. This will be done via the online SCR/SAR system and agencies will be required to provide the necessary information within 5 working days. Please see SCR/SAR Guidance for assistance in completing this request. Given the timescale required, any request for information will be proportionate.

4.4 The LSCB SCR sub group will discuss the collated information at either the next scheduled meeting or an extraordinary sub group convened specifically to discuss the notification.

4.5 The LSCB SCR sub group will consider the information and make a recommendation as to whether the SCR criteria have been met to the LSCB Chair. The group will also make a recommendation for a different type of review to be carried out if the criteria are not met.

4.6 The **LSCB Chair** will make the **final decision** which should normally be made within **15 working days** of the notification

The Rapid Review

The safeguarding partners should promptly undertake a Rapid Review of the case, in line with any guidance published by the National Panel. The aim of this Rapid Review is to enable safeguarding partners 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

As soon as the Rapid Review is complete, the safeguarding partners should send a copy to the National Panel. They should also share with the Panel their decision about whether a local child safeguarding practice review is appropriate, or whether they think the case may raise issues which are complex or of national importance such that a national review may be appropriate. They may also do this if, during the course of a local child safeguarding practice review, new information comes to light which suggests that a national review may be appropriate. As soon as they have determined that a local review will be carried out, they should inform the Panel, Ofsted and DfE, including the name of any reviewer they have commissioned.

The flow chart in Appendix 1 sets out the procedure described above.

4B How to Initiate a Serious Safeguarding Case and the Decision Making Process for the Safeguarding Partnership arrangement under Working Together 2018

The criteria which the local safeguarding partners 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

- 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.

5A. Notification of the Decision for LSCBs under Working Together 2015

5.1 If the Chairs decision is to progress with a SCR they will notify Ofsted, DfE and the National Panel of Independent Experts aware within five working days.

5.2 If the Chair's decision is not to initiate a SCR the decision will be subject to scrutiny by the National Panel. The Chair will inform the National Panel of the decision not to progress and will send the Panel the completed notification (Appendix 1) which includes the SCR sub groups recommendation and Chairs decision.

5.3 Where the National Panel require further supporting information regarding the decision making this will be provided and could include the information provided by agencies in Appendix 2 as well as the minutes of the SCR sub group meeting.

5.4 As set out in WT2015 if the *LSCB is challenged by the National Panel to change its original decision, the LSCB should inform Ofsted, DfE and the National Panel of the final outcome.'* (p78 WT2015)

5B. Notification of the Decision for Safeguarding Partnership arrangement under Working Together 2018

As soon as the rapid review is complete, the safeguarding partners via the SCR sub group, should send a copy to the National Panel. They should also share with the Panel their decision about whether local child safeguarding practice review is appropriate, or whether they think the case may raise issues which are complex or of national importance such that a national review may be appropriate. They may also do this if, during the course of a local child safeguarding practice review, new information comes to light which suggests that a national review may be appropriate. As soon as they have determined that a local review will be carried out, they should inform the Panel, Ofsted and DfE, including the name of any reviewer they have commissioned.

6. Engagement of Families

6.1 Engagement of families, children and service users. There is an increasing body of evidence that family members, including surviving children, can make a valuable contribution to professional understanding and should be invited to contribute to the review process. Consideration will be given to the earliest point that the family will be involved.

7A. Procedure for Carrying Out a SCR for LSCBs under Working Together 2015

7.1 Appendix 4 sets out what actions are required once agreement has been reached to commission a Serious Case Review.

7B. Procedure for Carrying Out a review of Serious Safeguarding cases for Safeguarding Partnership arrangements under Working Together 2018

Local child safeguarding practice reviews

The safeguarding partners should agree with the reviewer(s) the method by which the review should be conducted, taking into account this guidance and the principles of the systems methodology recommended by the Munro review88a way of looking at and analysing frontline practice as well as organisational structures and learning. The methodology should be able to reach recommendations that will improve outcomes for children. All reviews should reflect the child's perspective and the family context. . The methodology should provide

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

As part of their duty to ensure that the review is of satisfactory quality, the safeguarding partners should seek to ensure that:

- practitioners are fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith

- families, including surviving children, are invited to contribute to reviews. This is important 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 should be managed appropriately and sensitively

The safeguarding partners must supervise the review to ensure that the reviewer is making satisfactory progress and that the review is of satisfactory quality. The safeguarding partners may request information from the reviewer during the review to enable them to assess progress and quality; any such requests must be made in writing. The President of the Family Division's guidance covering the role of the judiciary in SCRs should also be noted in the context of child safeguarding practice reviews.

8A Publication of Reports for LSCBs under Working Together 2015

a. In order to provide transparency and to support the sharing of lessons learnt and good practice in writing and publishing such reports, all reviews of cases meeting the Serious Case Review criteria will result in a readily accessible published report on the LSCB's website. It will remain on the web-site for a minimum of 12 months and thereafter be available on request.

b. The fact that the report will be published must be taken into consideration throughout the process, with reports written in such a way that publication 'will not be likely to harm the welfare of any **children** or **Vulnerable Adults** involved in the case' and consideration given on how best to manage the impact of publication on those affected by the case. The LSCB will comply with the Data Protection Act 2018 and any other restrictions on publication of information, such as court orders.

c. The final Serious Case Review report should:

- Provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;

- Be written in plain English and in a way that can be easily understood by professionals and the public alike; and

- Be suitable for publication without needing to be amended or redacted.

d. The LSCB will publish, either as part of the final Serious Case Review report or in a separate document, information about:

- Actions already taken in response to the review findings;
- The impact these actions have had on improving services; and
- What more will be done

e. The LSCB will send copies of all Serious Case Review reports to the National Panel of Independent Experts at least one week before publication. If the LSCB considers that a report should not be published, it should inform the panel which will provide advice. The LSCB will provide all relevant information to the panel on request, to inform its deliberations.

8B Publication of Reports for Safeguarding Partnership arrangements under Working Together 2018

Safeguarding partners must ensure that 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

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.

Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond, so safeguarding partners must publish the report, unless they consider it inappropriate to do so. In such a circumstance, they must publish any information about the improvements that should be made following the review that they consider it appropriate to publish. The name of the reviewer(s) should be included. Published reports or information must be publicly available for at least one year.

When compiling and preparing to publish the report, the safeguarding partners should consider carefully how best to manage the impact of the publication on children, family members, practitioners and others closely affected by the case. The safeguarding partners should ensure that reports are written in such a way so that what is published avoids harming the welfare of any children or vulnerable adults involved in the case.

Safeguarding partners must send a copy of the full report to the Panel and to the Secretary of State no later than seven working days[91] before the date of publication. 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 and the Secretary of State within the same timescale. They should also provide the report, or information about improvements, to Ofsted within the same timescale.

Depending on the nature and complexity of the case, the report should be completed and published as soon as possible and no later than six months from the date of the decision to initiate a review. Where other proceedings may have an impact on or delay publication, for example an ongoing criminal investigation, inquest or future prosecution, the safeguarding partners should inform the Panel and the Secretary of State of the reasons for the delay. Safeguarding partners should also 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. Safeguarding partners should have regard to any comments that the Panel or the Secretary of State may make in respect of publication.

Every effort should also be made, both before the review and while it is in progress, to (i) capture points from the case about improvements needed, and (ii) take corrective action and disseminate learning.

Actions in response to local and national reviews

The safeguarding partners should take account of the findings from their own local reviews and from all national reviews, with a view to considering how identified improvements should be implemented locally, including the way in which organisations and agencies work together to safeguard and promote the welfare of children. The safeguarding partners should highlight findings from reviews with relevant parties locally and should regularly audit progress on the implementation of recommended improvements92. Improvement should be sustained through regular monitoring and follow up of actions so that the findings from these reviews make a real impact on improving outcomes for children.

9A. A Carrying out Learning and Improvements Through Undertaking a Multi-Agency Case Review for LSCB under Working Together 2015

The LSCB SCR sub group can also consider requests for convening multi-agency case reviews which do not meet the threshold for a serious case review and would benefit from a fuller review than what can be provided by the multi-agency audit sub groups. Chapter 4 of WT15 sets out the requirement to undertake these linked to the LSCB Learning and Development Framework.

The purpose of these reviews is to provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children. Although this is not a statutory requirement these reviews are important for highlighting good practice as well as identifying improvements which need to be made to local services. This is set out in Regulation 5(2). The LSCB Chair should be confident that their review will thoroughly, independently and openly investigate the issues. The LSCB will also want to review any instances of good practice and to consider how these can be shared and embedded into practice. The LSCB sub group should oversee implementations of actions resulting from these reviews and reflect on any progress in its annual report.

9B Under the new Safeguarding Partnership arrangement and Working Together 2018 we will either conduct a local review as Section 7B or a National review will take place, both of which will be preceded by a Rapid Review.

10. Procedure for Carrying Out a Multi-Agency Review for LSCB under Working Together 2015

10.1 Where an agency believes the SCR criteria is not met but that a multi-agency review would be of benefit they should still complete the online notification and suggest an alternative type of review be considered.

10.2 The LSCB SCR sub group will consider the information provided on the notification form and follow the flowchart in Appendix 5, decide the type of review to take place and recommend this to the LSCB Chair for approval.

10.3 The SCR sub group will be responsible for monitoring any related action plan which is agreed as part of the review.

10.4 WT2015 does not prescribe any particular methodology to use in continuous learning and improvement except that whatever model is used should be conducted in a way that adheres to the following 5 principles:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations; involved at the time rather than using hindsight;
- Transparency about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

10.5 WT2015 stops short of advocating any specific method. However, the systems methodology as recommended by Professor Munro (**The Munro Review of Child Protection: Final Report: A Child Centred System** is cited as an example of a model that is consistent with these principles. https://www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system

10.6 The following principles should be applied by the LSCB and partners organisations to all reviews

- **The child to be at the centre of the process**
- **A proportionate response:** according to the scale and complexity of the issues being examined i.e. the scale of the review is not determined by whether or not the circumstances meet statutory criteria

- **Independence:** reviews of serious cases to be led by individuals who are independent of the case and of the organisations being reviewed
- **Involvement**: of practitioners and clinicians: Professionals should be fully involved in reviews and invited to contribute their perspective without fear of blame for actions they took in good faith
- **Family involvement:** Families, including surviving children, should be invited to contribute and be provided with an understanding of how this will occur
- **Transparency:** by publishing the final report of the Serious Case Review and the LSCBs findings. The LSCB annual reports should explain the impact of the serious case review and other reviews on improving services to children and families and on reducing incidence of deaths or serious harm
- **Embedding learning:** using a range of creative communication and methodologies
- **Sustainability**: improvement must be sustained through regular monitoring and following up the finding from these reviews that make a real impact on improving outcomes for children

11. Parallel processes

11.1 Safeguarding Adults Review

Under the Care Act 2014 a Safeguarding Adults Review can only be commissioned by the Safeguarding Adults Board.
There is a statutory duty on the Board to arrange a review of adult (aged 18 plus) in its area with needs for care and support (it is not relevant to this duty for these needs to have been met by the provision of care and support funded by the individual or other public bodies) if:

a. There is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other organisations worked together to safeguard the person. **And**

b. The person has died and the Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died). **Or**

c. The person is still alive and the Safeguarding Adults Board knows or suspects that they have experienced serious abuse or neglect. In these situations serious abuse or neglect would be indicated if:

- The individual would have been likely to have died had there not been some form of intervention or they have suffered permanent harm
- The person has experienced reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

Safeguarding Adults Reviews undertaken under these criteria are described as statutory reviews in this guidance.

The Act also gives a Safeguarding Adults Board the opportunity to arrange a review in other situations involving an adult in its area with needs for care and support if it is felt there would be learning to be obtained. The Bath and North East Somerset Safeguarding Adults Board will consider requests to undertake a non- statutory review in a situation where:

a) An adult has received support through the Safeguarding Adult's process due to concerns of abuse or neglect **and**

b) Whilst there are no concerns about the way that individuals within agencies have worked together, there is evidence that the policies and procedures of one or a number of the agencies involved did not support this joint working. This may include issues around the sharing of information or the use of resources **or**

c) There are examples of good practice that could be used to identify lessons that could be applied by agencies when working with adults at risk in the future.

A SAR might also be running at the same time if the incident involves a family, exploitation or someone approaching 18.

11.2 NHS Serious Incident Investigations

Serious Incidents in the NHS include abuse that resulted in (or was identified through) a Serious Case Review (SCR). The revised National Health Service England (NHSE) serious incident framework, implemented from April 2015, explains the responsibilities and actions for dealing with Serious Incidents. It outlines the process and procedures to ensure that Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. Healthcare providers must contribute towards SCR's as required to do so by the Local Safeguarding Board.

(See **Serious Incident Framework: Supporting learning to prevent recurrence, NHS England (Updated: March 2015)**.

When the NHS is involved in a SCR, an NHS Serious Incident Investigation is carried out in parallel coordinated by a Designated Safeguarding Professional employed by the Clinical Commissioning Group (CCG). The Serious Incident investigation must include all provider organisations that were involved in the child's care during the period of time under review. Lessons will be defined and recommendations and actions made with regards to NHS interdepartmental, interdisciplinary and inter-agency working as well as those for multi-agency practice. The NHS Serious Incident Investigation must use Serious Incident RCA systems methodology, which is compliant with the principles in Working Together to Safeguard Children 2015. The CCG Designated Safeguarding Professional coordinating the case must have an early discussion and agree with the Chair of the Safeguarding Board the ways in which the SI investigation can best inform the SCR whilst avoiding duplication, for example by enabling health to undertake joint interviews with the LSCB lead reviewer for the health professionals involved, and attending all SCR multi-agency review meetings and learning events.

11.3 Domestic Homicide Reviews

When there has been a death of an individual of 16 years or over which has, or appears to have, resulted from violence, abuse or neglect by a person to whom s/he was related to, had been in an intimate personal relationship or was a member of the same household then a Domestic Homicide Review (DHR) or Serious Incident review will be undertaken. If the deceased person was 16 – 18 years then a Serious Case Review will be undertaken, with the Domestic Violence fully considered and shared with the Community Safety Partnership. The LSCB is involved in all reviews where there are children living in the house and the findings and recommendations are shared with the LSCB.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97881/DHR-guidance.pdf

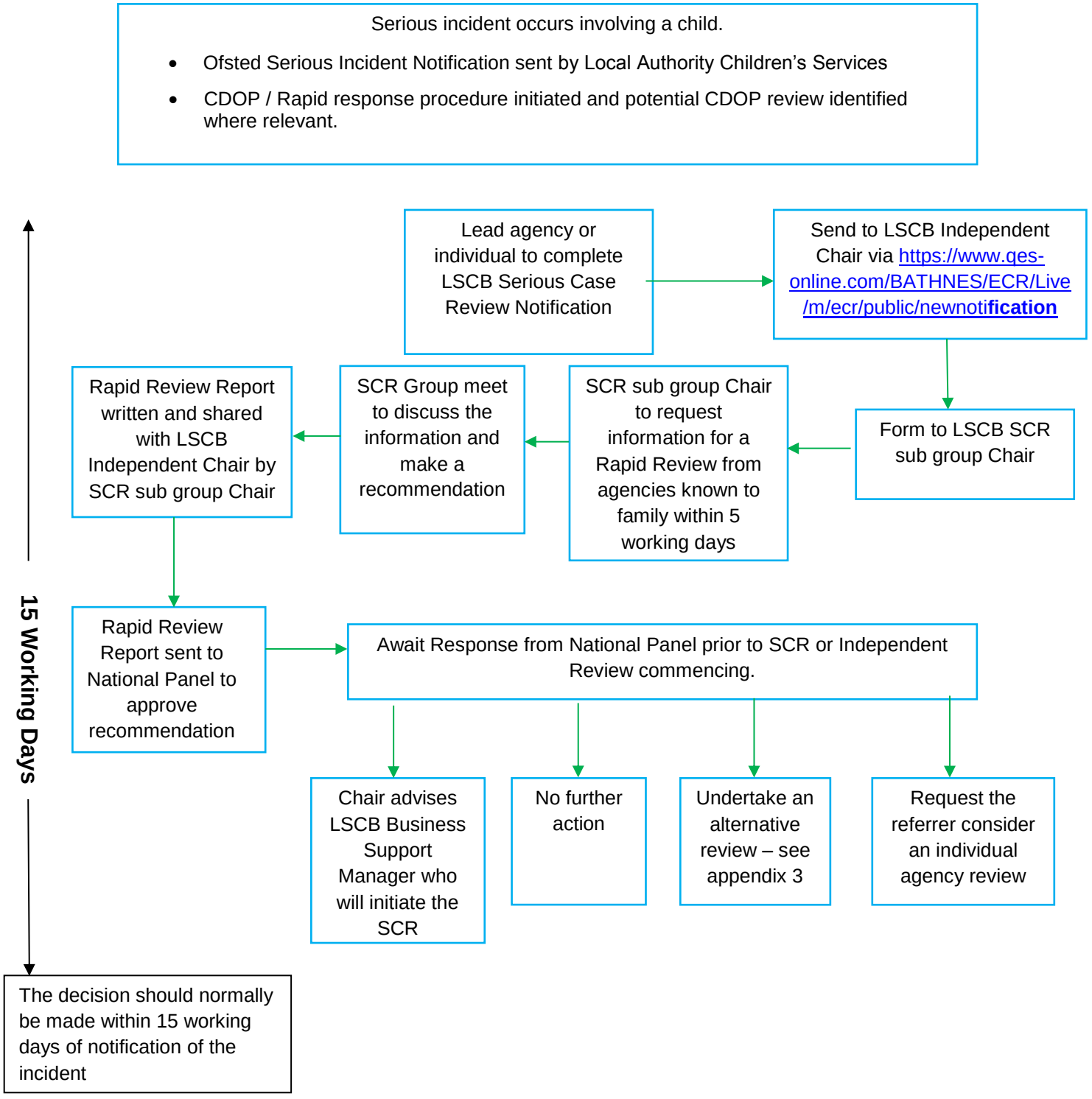
11.4 Criminal investigation/prosecution

Where a Serious Case Review is to take place where there are to be criminal proceedings, the LSCB and Police will operate within the Crown Prosecution Service suggested framework for the sharing and exchange of relevant information which can be found on the CPS website:
http://www.cps.gov.uk/publications/docs/liaison_and_information_exchange.pdf.
The framework deals with the process of a serious case review and how it may affect the conduct of the criminal investigation/prosecution. Both criminal proceedings and serious case reviews are crucial to the effective safeguarding of children and should be carried out as expeditiously as possible and without one adversely affecting the other. The CPS suggested framework should be read in conjunction with wider CPS Legal Guidance on the CPS website:
http://www.cps.gov.uk/legal/s_to_u/serious_case_review/index.html.

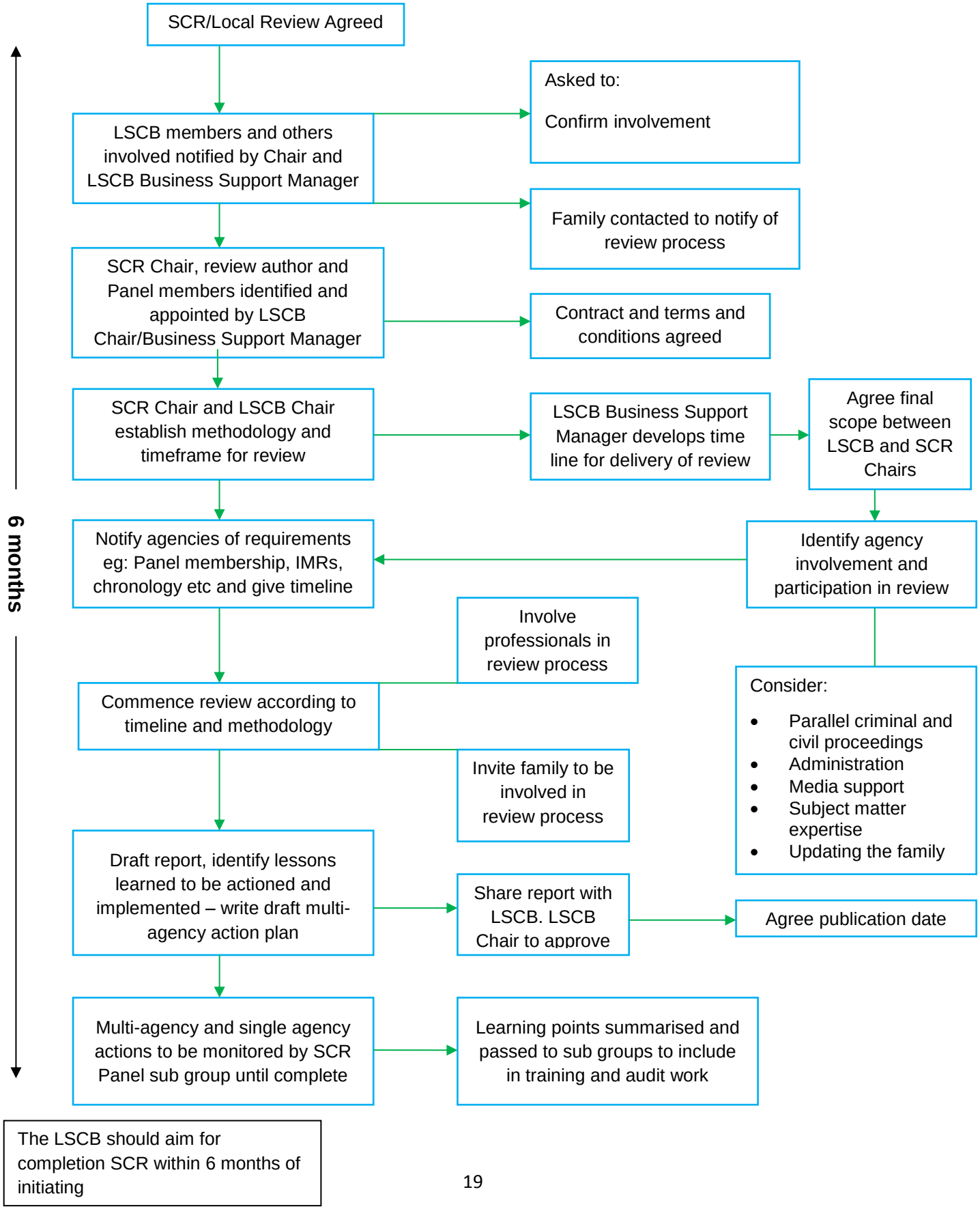
12. Further Information

- https://www.gov.uk/government/publications/childrens-safeguarding-performance-information-framework
- https://www.gov.uk/search?q=Working+Together+to+Safeguard+Children
- https://www.gov.uk/government/publications/munro-review-of-child-protection-interim-report-the-childs-journey
- https://www.gov.uk/government/publications/good-practice-by-local-safeguarding-children-boards
- https://www.gov.uk/government/consultations/inspection-of-services-for-children-in-need-of-help-and-protection-children-looked-after-and-care-leavers
- https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2
- https://www.gov.uk/government/publications/keeping-children-safe-in-education--2

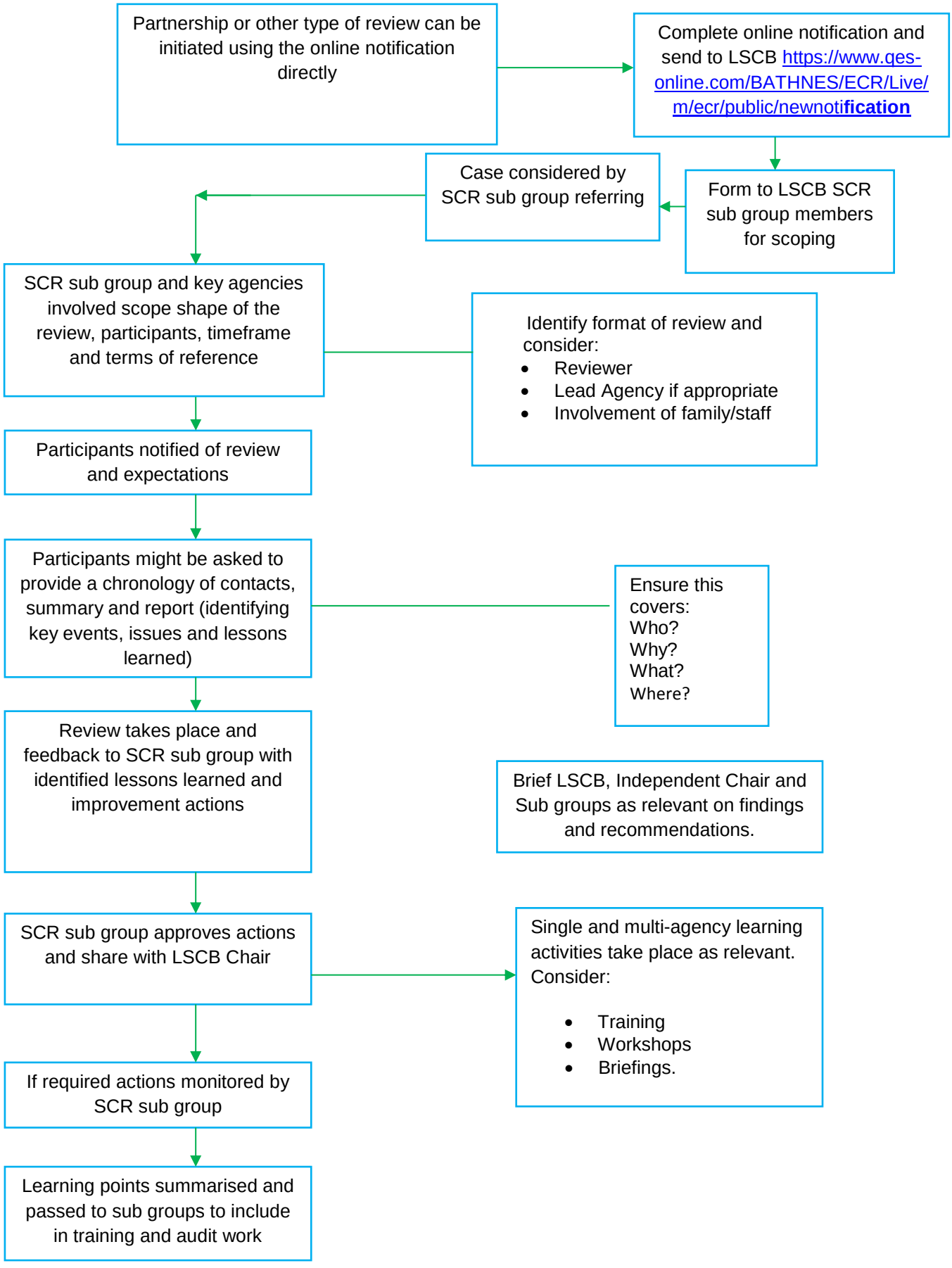
Appendix 1: Serious Case Review Consideration and Decision WT2015/Rapid Review



Appendix 2: Serious Case Reviews/Local Child Safeguarding Practice Review



Appendix 3: Partnership or Other Type of Multi-Agency Review



LSCB
Bath & North East Somerset
Local Safeguarding Children Board

Appendix 4: Serious Case Review checklist / guidance

Notification

The Safeguarding Partners (LSCB) should let Ofsted and the National Panel of know their decision within five working days of the Chair's decision.
If the LSCB recommends not initiating an SCR, their decision will be subject to scrutiny by the National Panel. The LSCB should provide sufficient information in their Rapid Review Report to the Panel to inform its deliberations. In cases where an LSCB is challenged by the National Panel to change its original decision, the LSCB should inform Ofsted, and the National Panel of the final outcome.

Commissioning a reviewer or reviewers for a local child safeguarding practice review

The safeguarding partners are responsible for commissioning and supervising reviewers for local reviews.

In all cases they should consider whether 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

Engagement of organisations

The Safeguarding Partners (LSCB) should ensure that there is appropriate representation in the review process of professionals and organisations who were involved with the child and family. The priority should be to engage organisations in a way which will ensure that important factors in the case can be identified and

appropriate action taken to make improvements. The LSCB may decide as part of the SCR to ask each relevant organisation to provide information in writing about its involvement with the child who is the subject of the review.

Timescale for SCR completion and publication

When compiling and preparing to publish the report, the safeguarding partners should consider carefully how best to manage the impact of the publication on children, family members, practitioners and others closely affected by the case. The safeguarding partners should ensure that reports are written in such a way so that what is published avoids harming the welfare of any children or vulnerable adults involved in the case.

Depending on the nature and complexity of the case, the report should be completed and published as soon as possible and no later than six months from the date of the decision to initiate a review. Where other proceedings may have an impact on or delay publication, for example an ongoing criminal investigation, inquest or future prosecution, the safeguarding partners should inform the Panel and the Secretary of State of the reasons for the delay. Safeguarding partners should also 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. Safeguarding partners should have regard to any comments that the Panel or the Secretary of State may make in respect of publication.

Safeguarding partners must send a copy of the full report to the Panel and to the Secretary of State no later than seven working days before the date of publication. 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 and the Secretary of State within the same timescale. They should also provide the report, or information about improvements, to Ofsted within the same timescale.
Every effort should also be made, both before the review and while it is in progress, to (i) capture points from the case about improvements needed, and (ii) take corrective action and disseminate learning.

Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond, so safeguarding partners must publish the report, unless they consider it inappropriate to do so. In such a circumstance, they must publish any information about the improvements that should be made following the review that they consider it appropriate to publish. The name of the reviewer(s) should be included. Published reports or information must be publicly available for at least one year.

Appendix 5: Guidance for the National Child Safeguarding Practice Review Panel

On receipt of the information from the rapid review, the Panel must decide whether it is appropriate to commission a national review of a case or cases. They must consider the criteria and guidance below.

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

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

As well as considering notifications from local authorities and information from rapid reviews and local child safeguarding practice reviews, the Panel should take into account a range of other evidence, including inspection reports and other reports and research. The Panel may also 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.

In many cases there will need to be dialogue between the safeguarding partners and the Panel to support the decision-making process. The safeguarding partners must share further information with the Panel as requested.

The Panel should inform the relevant safeguarding partners promptly following receipt of the rapid review, if they consider that:
• a national review is appropriate, setting out the rationale for their decision and next steps
• further information is required to support the Panel's decision-making (including whether the safeguarding partners have taken a decision as to whether to commission a local review)

The Panel should take decisions on whether to undertake national reviews and communicate their rationale appropriately, including to families. The Panel should notify the Secretary of State when a decision is made to carry out a national review.
27. If the Panel decides to undertake a national review they should discuss with the safeguarding partners the potential scope and methodology of the review and how they will engage with them and those involved in the case.

There will be instances where a local review has been carried out which could then form part of a thematic review that the Panel undertakes at a later date. There may also be instances when a local review has not been carried out but where the Panel considers that the case could be helpful to a national review at some stage in the future. In such circumstances, the Panel should engage with safeguarding partners to agree the conduct of the review.

Alongside any national or local reviews, there could be a criminal investigation, a coroner's investigation and/or professional body disciplinary procedures. The Panel and the safeguarding partners should have clear processes for how they will work with other investigations, including Domestic Homicide Reviews, multi-agency public protection arrangements reviews or Safeguarding Adults Reviews, and work collaboratively with those responsible for carrying out those reviews. This is to reduce burdens on and anxiety for the children and families concerned and to minimise duplication of effort and uncertainty.