Bexley S.H.I.E.L.D.

Safeguarding Partnership for Children and Young People

Serious Child Safeguarding Incident Procedures

Purpose

These procedures seek to support Bexley S.H.I.E.L.D. and its partners to ensure robust systems are in place for reporting, investigating and responding to serious incidents so lessons are learned and appropriate action taken to prevent future harm. They comply with statutory guidance set out in Chapter 4, Working Together 2018 and with the National Child Safeguarding Practice Review Panel: practice guidance issued in April 2019.

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Part 1	**Definitions and Thresholds**

1.1. What is a serious child safeguarding incident?

Bexley S.H.I.E.L.D. takes its definition of a serious child safeguarding incident or case from Working Together to Safeguard Children (Department for Education, 2018) where:

- 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;

1.2. What is meant by Serious Harm?

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[1]. 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. (DfE, 2018). (Paragraph 11, Chapter 4, Working Together 2018)

When deciding whether the level of harm to a child is serious, often this judgement is quite straight forward. For example, because the child has a life-changing and long-term injury or an injury that is clearly life-threatening, for example, requiring resuscitation or intensive care treatment. However, some incidents are not so straight forward and, in these circumstances, a judgement about seriousness is likely to be made. (page 13, Child Safeguarding Practice Review Panel: practice guidance)

1.3. How are serious incidents identified?

Any member of staff across any organisation may become aware of a serious incident. If you think a serious incident has occurred, discuss this with the safeguarding lead in your organisation to determine if it meets the threshold outlined above and report it to the Safeguarding Partnership using the notification form attached at **Appendix 1**.

Your own organisation may conduct an internal review following the serious incident, however if the case meets any of the criteria outlined above, it must also be reported to Bexley S.H.I.E.L.D.

In the case of a child death, all child deaths must be reported to the Single Point of Contact for Bexley and the Child Death Overview Panel will review all child deaths irrespective of whether abuse or neglect is known or suspected. It is a statutory requirement to review all child deaths and there are separate CDOP Procedures available on the Safeguarding Partnership website. Cases may be referred to Bexley S.H.I.E.L.D. via the Child Death Overview Panel if it is identified that abuse or neglect is known or suspected or that the child was looked after or in a regulated setting or service. All child deaths involving a child with a Bexley address should be submitted using a Form A notification via the Tri-borough e-CDOP system.

[1] Child perpetrators may also be the subject of a review, if the definition of 'serious child safeguarding case' is met.

From September 2019, Bexley, Lewisham and Greenwich have agreed to combine and be treated as a single area for child death reviews. A single central team will support all aspects of the management and administration of the child death review process. Each borough will have its own designated doctor for child deaths. Further information is contained in the following document:
Bexley, Lewisham, Greenwich Child Death Review Process, July 2019

If you would like to discuss a case with the Safeguarding Partnership Operations team please email shield@bexley.gov.uk or telephone 020 3045 4320.

1.4. Types of review

Summary

Bexley S.H.I.E.L.D. may recommend a National Child Safeguarding Practice Review or commission or oversee one of the following forms of case review:

National Child Safeguarding Practice Review	A child has died or been seriously harmed and abuse or neglect is known or suspected **and** there is cause for concern as to the way in which the authority, Board partners or other relevant persons have worked together to safeguard the child **and** the partnership identifies it as a case of national significance. *The national panel would be responsible for publishing the review. A briefing note for practitioners would also be published in Bexley to ensure key learning is disseminated across the partnership.*
Local Child Safeguarding Practice Learning Review (previously known as a Serious Case Review)	A child has died or been seriously harmed and abuse or neglect is known or suspected **and** there is cause for concern as to the way in which the authority, Board partners or other relevant persons have worked together to safeguard the child. OR (ii) the serious incident criteria are not met but the case is of local significance and the partnership considers a child safeguarding practice review is necessary and valuable. *Independently reviewed. Full chronology template and Single Agency Individual Management Reports (IMRs) required.* *The expectation is that the final review is published (unless there are exceptional circumstances). A briefing note for practitioners would also be published to ensure key learning is disseminated across the partnership.*
Partnership Review	(i) A child has died or been seriously harmed and abuse or neglect is known or suspected **and** there are multi-agency learning points to improve the way in which agencies safeguard and promote the welfare of children OR (ii) the serious incident criteria are not met but the case is of local significance and the partnership considers a partnership review is necessary and valuable.

	Independently reviewed or may be reviewed Peer reviewed by a suitably trained and experienced colleague in Lewisham or Greenwich. *These type of review are not published. However, a briefing note for practitioners would be published to ensure key learning is disseminated across the partnership.*
Multi-Agency Audit	(i) A child has been seriously harmed and abuse or neglect is known or suspected and there are multi-agency learning points to improve the way in which agencies safeguard and promote the welfare of children OR (ii) the serious incident criteria are not met but the case is of local significance and the partnership considers a multi-agency audit necessary and proportionate. *The Multi-Agency Audit is led by the Practice Review and Learning Manager or other member of Safeguarding Partnership Operations Team who will identify the multi-agency audit team.* *Audit findings are not published. However, a briefing note for practitioners would be published to ensure key learning is disseminated across the partnership.*
Individual Agency Review	A child has died or been seriously harmed and abuse or neglect is known or suspected **and** there are single-agency learning points to improve the way in which a single agency safeguard and promote the welfare of children. *These types of review are not published. However, a briefing note for practitioners would be published to ensure key learning is disseminated across the partnership.*

Detail

National Child Safeguarding Practice Reviews

The National Panel are notified of the incident explaining the recommendation for a National Review based on the information gathered in the Rapid Review, and any other relevant rationale. If the panel agrees this is a proportionate and appropriate next step, they will coordinate the review and feedback to the operations team or other designated lead within the Local Authority. National Reviews are generally considered when a serious incident occurs which is considered to be of National interest. The panel will have final say over whether this is considered a proportionate response and take the lead in the oversight of the review. The National Panel may make alternative suggestions for a review and this should be fed back to the partnership and then followed up in action accordingly, letting the Learning from Practice Group members know of the outcome.

Local Child Safeguarding Practice Learning Reviews (Serious incident criteria met)

When the criteria for a Safeguarding Practice Review is met, the local Learning from Practice Group will determine the most appropriate way in which to conduct a review. The terms of reference and methodology will be decided on a case-by-case basis. They will also identify the reviewer and ensure the review is completed within six months or less. The report on the review will be shared with the National Panel.

The initial recommendation about conducting a Child Safeguarding practice review lies with the Learning from Practice Group. If there is disagreement within the group regarding final recommendation, then the S.H.I.E.L.D. Executive will be consulted and provided with report on

recommendations and rationale. The three key partners will consider the recommendations and make a final decision based on the majority view.

Once a Local Child Safeguarding Practice Learning Review is agreed, the Learning from Practice Group will assume responsibility for agreeing the terms of reference and commissioning an independent reviewer, and discuss with the S.H.I.E.L.D. Executive any decisions about publishing any completed reviews. It will also cover agreement on the ownership and location of any related action plans and who will lead in any discussions with the national panel.

Partnership Review /Multi-Agency Audit (Serious incident criteria is not met but learning review still considered necessary and valuable.)

An informal review which does not meet criteria for referring to the National Panel or being reviewed independently. It does not meet criteria for serious incident or notification, and local learning can be achieved proportionately through an audit exercise, or Practice Learning Event. For example, the audit or partnership review could incorporate a practice learning and reflection event in the same way as a more formal review and with an audit panel agreed to oversee and facilitate. This will ensure a concise, multi-agency and in-depth approach to completing an audit with participation from practitioners and leads representing agencies and involvement with the family. Action plans arising from this can then be formulated in a timely way and the learning embedded as soon as possible and shared with operational and strategic leads.

Individual Agency Review

Individual agencies will have their own mechanisms for conducting reviews. If this is the recommended action, then the process and outcome of such a review should be made clear and be included in a report with agreement on how outcomes will be shared and taken into account for wider learning. Reports on any reviews to be shared with the partnership.

1.5. Notifying the National Panel and Bexley S.H.I.E.L.D.

The local authority must report any incident that meets the criteria outlined at 1.1 to the National Child Safeguarding Practice Review Panel and Bexley S.H.I.E.L.D. promptly, and within five working days of becoming aware that the incident has occurred. If an incident meets the criteria for a Serious Child Safeguarding Incident, then it will also meet the criteria for a notifiable incident. There will, however, be notifiable incidents that do not proceed through to Child Safeguarding Practice Review.

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 National Panel[2]. They should do so within five working days of becoming aware that the incident has occurred.

[2] Online notifications to the Panel will be shared with Ofsted (to inform its inspection and regulatory activity) and with DfE to enable it to carry out its functions.

The local authority should also report the event to the Bexley S.H.I.E.L.D. via the Safeguarding Partnership Operations team (and other local safeguarding partnerships if appropriate[3]) no later than **five working days** of becoming aware of a serious incident.

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 National Panel rests with the local authority. Others who have functions relating to children should inform the safeguarding partnership of any incident which they think should be considered for a child safeguarding practice review. The link to the Child Safeguarding Online Notification form for local authorities to notify incidents to the Panel is available from Report a serious child safeguarding incident page on Gov.uk" (Paragraphs 12-14, Chapter 4, Working Together 2018

The Children's Services procedures for notifying a Serious Incident to the Deputy Director, Children's Social Care are available at: https://bexley.proceduresonline.com/p_ser_incid_notif_pol.html

[3] If, for example, the event relates to a looked after child who has been placed out of area.

Part 2	**Underpinning Principles**

2.1 The purpose of child safeguarding practice reviews

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.

Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose. (paragraphs 3 and 4, Working Together 2018)

2.2 The role of Safeguarding Partnership in dealing with serious incidents

Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken. (Paragraph 7, Chapter 4, Working Together 2018)

The Safeguarding Partnership promotes a culture of continuous learning and improvement. Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.

Local child safeguarding practice reviews and child death reviews are required under legislation, however reviews are also conducted on cases which can provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children. Although not required by statute, these reviews are important for highlighting good practice as well as identifying improvements which need to be made to local services. Such reviews may be conducted either by a single organisation or by a number of organisations working together and this learning is actively shared with relevant agencies.

2.3 Impact of a review on the family, staff and managers

The death or serious injury of a child will undoubtedly be emotive and cause a measure of anxiety, worry, and upset for those most directly involved, such as the family and front line professionals and their managers. This can sometimes lead professionals to become defensive, blame, or prematurely react in an effort to be seen as doing something to resolve the situation quickly. This often contributes to the creation of unnecessary bureaucracy and hampers people's ability to contribute in an open and collaborative manner in order to have a clear understanding of what occurred and what lessons can be learned.

It is therefore important for senior leads in the safeguarding partnership to exercise a measure of emotional intelligence and compassionate management of the situation appreciating the human impact such a tragedy will have on all involved. This is key in establishing a culture where people are enabled to speak honestly so as to establish not just want they may have, or have not, done, but also their rationale for doing so.

Where reviews are taking place concurrently with other criminal and child protection enquiries, it will be important for senior leads in each organization to clearly communicate:

- An acknowledgement of the seriousness of the tragedy and that our thoughts are with the managers, practitioners, and family members impacted;
- Explain that police and child protection enquiries are ongoing and being expedited and that further communication will be forthcoming at the earliest opportunity;
- Where practitioners and family members can seek support during this time.

Where criminal and child protection enquiries may be concluded and a review is being resumed, it needs to be acknowledged that having to again discuss the details of the tragedy will likely reignite people's anxieties, worries, and upset. It is important this is acknowledged as part of the process, including in the invite letters sent to those participating in the review. This should include where they could seek support, such as occupational health, GP, and Samaritans.

2.4 Information Sharing

In order to assure a co-ordinated response that fully addresses all systematic concerns surrounding serious incidents, all relevant data should be shared and reviewed as permitted within the stipulations of the Data Protection Act, the General Data Protections Regulations, the Caldicott Principles and Working Together to Safeguard Children (DfE, 2018). Agency representatives involved in the review process must sign a confidentiality agreement, including sharing and securely storing information. In no case should any agency representative disclose any information pertaining to any individual case other than pursuant to the mandated agency responsibilities of that individual or for the purposes of joint investigations.

2.5 Criteria for a Local Child Safeguarding Practice Review

When a serious incident becomes known to the safeguarding partners[4], they must consider whether the case meets the criteria for a local review.

Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice. Issues might appear to be the same in some child safeguarding cases but reasons for actions and behaviours may be different and so there may be different learning to be gained from similar cases. Decisions on whether to undertake reviews should be made transparently and the rationale communicated appropriately, including to families'. (DfE, 2018). (Paragraphs 16 and 17, Chapter 4, Working Together 2018)

Safeguarding partners must consider the criteria and guidance below when determining whether to carry out a local child safeguarding practice review.

The criteria which the Safeguarding Partnership 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

[4] Safeguarding partners should also take account of information from other sources if applicable.

- 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 (Paragraph 18, Chapter 4, Working Together 2018)

The 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[5] ((Paragraph 18, Chapter 4, Working Together 2018)

Additional guidance for the safeguarding partnership to consider in deciding whether to undertake a local review

As noted in Part 1, the list of what constitutes 'serious harm' is not an exhaustive list. There is no definitive list of events/incidents that constitute a serious incident, as this could lead to inconsistent or inappropriate management of incidents. Where full lists are created there may be a tendency to not appropriately investigate things that are not on the list even when they should be investigated, and equally a tendency to undertake full reviews of incidents where that may not be warranted, simply because they seem to fit a description of an incident on a list.

The definitions in Part 1 sets out circumstances in which a serious incident must be declared. Every incident must be considered on a case-by-case basis. Inevitably, there will be borderline cases that rely on the judgement of the people involved. Managing, investigating and learning from serious incidents requires a considerable amount of time and resource. Care must be taken to ensure there is an appropriate balance between the resources applied to the reporting and reviewing individual incidents and the resources applied to implementing and embedding learning to prevent recurrence. The former is of little use if the latter is not given sufficient time and attention.

Where the safeguarding partnership identifies a number of serious incidents involving the same key theme, it should consider undertaking a multi-incident review. If it can demonstrate evidence of this and the improvements being made, this can be used as a way of managing and responding to other similar incidents within an appropriate timeframe. This means that if another similar incident occurs before the agreed target date for the implementing of preventative actions/improvement plans, a separate review may not be required. Instead consideration should be given to whether resources could be better used on the delivery of improvement work rather than initiating another review. This would need careful assessment, engagement with those affected and agreement on a case-by-case basis.

[5] Includes children's homes (including secure children's homes) and other settings with residential provision for children; custodial settings where a child is held, including police custody, young offender institutions and secure training centres; and all settings where detention of a child takes place, including under the Mental Health Act 1983 or the Mental Capacity Act 2005.

Criteria is not met for Serious Incident but there are concerns regarding how agencies have worked with or responded to a child or young person.

The Learning from Practice Group can consider conducting reviews on cases which do ***not*** meet the local child safeguarding practice review criteria. If a local child safeguarding practice review is not required because the criteria in regulation 5(2) are not met, the Learning from Practice group may still decide to commission a local child safeguarding practice review or they may choose to commission an alternative form of case review, such as a multi-agency partnership review and or including an audit. The Chairperson for the Learning from Practice Group should be confident that such any review or audit will thoroughly, independently and openly investigate the issues.

The matter will be will be heard by the Learning from Practice Group as soon as possible and the referrer will be invited to present the case to the Learning from Practice Group for consideration. The Learning from Practice Group or equivalent will consider the information provided and establish if the criteria for a local learning review or audit is met. The methodology for review will be also be considered.

The local Safeguarding Partnership operations team can be contacted for advice if you are concerned about a child, and or a serious incident and need guidance on criteria.

Professionals should use the Referral & Notification Form to refer cases to the Learning from Practice Group. All outcomes to referrals for Learning Reviews will be fed back to referrer and rationale for recommendations.

Professionals should always follow internal processes for discussing cases of concern with their manager and safeguarding lead. In most organisations, the responsibility for referring a case to the Learning from Practice Group lies with the named safeguarding lead. Professionals are required to complete a notification form (**Appendix 1**) at the earliest opportunity and send it to Bexley S.H.I.E.L.D. at: shield@bexley.gov.uk .

Notification of a concern from members of the public. parents etc

Parents and members of the community can make referrals to the Learning from Practice Group if they are concerned about how services worked together to ensure a child's welfare and/or safety. Enquiries should be made in the first instance to the Practice Review and Learning Manager and operations team, who will then support the referrer with the referral process and completing the referral form, to ensure the Learning from Practice group is in receipt of the necessary information to make an informed decision.

The safeguarding operations team should communicate with any referrer the outcome of the rapid review meeting and/or learning from practice group meeting proposed next steps.

If you would like to discuss a case with the operations team, please email shield@bexley.gov.uk or telephone 020 3045 4320.

2.6 Involvement of the family

All types of review should consider how the family will be involved in the review at an early stage and as part of developing the terms of reference or scope. Convening such a review will likely be an emotive situation for the family, invoking strong feelings and possibly be re-traumatising, especially if other enquiries and investigations have already taken place. The purpose of the review must be clearly conveyed to the family in a way that does not assume they will know its purpose or process. Consideration needs to be given to the age, learning, and communication needs of those being invited, It should be acknowledged this may likely be emotive and they may wish to consider seeking support or advocacy. Please see **Appendix 10** for an example letter to the family for a local Child Safeguarding Practice Review.

Involvement of the family (tailored to their needs) should be considered at each stage of the review process including the need for advocacy. The rapid review should consider any immediate actions for support and then advocacy or support throughout the review. Further information on family involvement can be found in section 3.4.

2.7 Briefing notes for practitioners

In order to disseminate the learning across agencies, a briefing note on the key learning points for practitioners will be produced for all types of review by the safeguarding partnership operation team. Please see **Appendix 12** for the briefing note template.

Part 3	**Serious Incident Management Process**

2.1. Notification

Any member of staff may make a referral to Bexley S.H.I.E.L.D. regarding a serious incident, however, it is advisable to first discuss this with the safeguarding lead in your organisation. The Serious Incident Referral Form must be completed as fully as possible and emailed to shield@bexley.gov.uk **no later than five working days** of becoming aware that a serious incident has occurred. A copy of the referral form is available at **Appendix 1**.

If the case does not meet the criteria for a serious incident set out a section 1.1, agencies can refer a case instead for a Partnership Review or Multi-Agency Audit using the form attached at **Appendix 2**.

2.2. Consideration by the Practice Review and Learning Manager

The Practice Review and Learning Manager will acknowledge the referral within one working day of receipt of the Serious Incident Notification Form. The Practice Learning and Review Manager will notify the 3 key partners of any potential serious incident criteria being met. (In their absence this will be undertaken by a member of the operations team.)

2.3. Rapid Review Meeting

The safeguarding partners should promptly undertake a rapid review of cases which meet the criteria outlined in sections 1.1 and 2.3, in line with any guidance published by the Panel (see below). 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.

Timescales and information requirements

In Bexley if the case meets the threshold, a Rapid Review Meeting will be convened within ten working days of receiving the notification. The Agency proforma template (see **Appendix 5**) will be emailed to agency representatives who are asked to return to shield@bexley.gov.uk within five working days, at which point all papers will be emailed to agency representatives ahead of the meeting. N.B.: representatives may use their own agency's chronology template providing it sufficiently details the significant events in the case.

The purpose of the Rapid Review Meeting is to, consider the information held by each agency, and determine whether the case meets the criteria for a local child safeguarding practice review or an alternative form of case review. A record of the meeting will be emailed to agency representatives within five working days of the meeting. The Learning from Practice Group will make a recommendation to the S.H.I.E.L.D. Executive on the form of case review required. The final decision will be for the S.H.I.E.L.D. Executive and agency representatives will be emailed the outcome.

When the criteria outlined at 1.1 for a serious child safeguarding case is met, a rapid review meeting will be convened with the Learning from Practice Group, and any other members from appropriate services involved with the case in question. If the criteria is not met, then the case will be considered at the next Learning from Practice Group meeting.

Rapid review must meet the standard required by Working Together guidance but must also be proportionate to the complexity and seriousness of the issues raised by the case. For example, if a case clearly meets the criteria**,** the focus of the rapid review will be on the potential learning from the case, and consider any immediate steps which need to be taken in relation to systemic or practice issues.

In the event that further clarification is needed in relation to whether to conduct a review or not, the Learning from Practice Group might request further information from agencies at the initial Rapid Review meeting. Once all the information has been considered and a decision has been reached, the Learning from Practice group (via the Practice Review and Learning Manager) will inform the respective S.H.I.E.L.D. Executive leads of their recommendation. This needs to be achieved within 13 days.

All notifications and rapid review reports, regardless of their conclusions or next steps, will be copied to the 3 key partners to ensure the Partnership leaders are routinely sighted on individual cases. This is both an important principle but also a recognition of their responsibility to lead any necessary system changes.

All reports should share with the 3 key partners any thoughts on whether the case may raise issues which are complex or of national importance such that a National Review may be appropriate, and or whether they plan to carry out a local child safeguarding practice review even though the criteria is not met.

As soon as the rapid review is complete, the safeguarding partners should send a copy to the National Panel Mailbox.NationalReviewPanel@education.gov.uk. 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 Mailbox.NationalReviewPanel@education.gov.uk, Ofsted scr.sin@ofsted.cjsm.net and DfE Mailbox.CPOD@education.gov.uk, including the name of any reviewer they have commissioned. (Paragraphs 20 and 21, Chapter 4, Working Together 2018)

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

Outcome of the Rapid Review

As a minimum the outcome of the rapid review must record:

- whether or not the case in question is being considered against the criteria set out in Working Together (2018);
- 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 child safeguarding practice review 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 their dissemination;
- potential for additional learning;
- if the decision is taken not to proceed with a local child safeguarding practice review, 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 be usually expected;
- who has been involved in the decision-making process; and,
- relevant identifying details of the child and family.

(page 15, Child Safeguarding Practice Review Panel: practice guidance)

See **Appendix 6** for template of outcome of a rapid review.

2.4. Local Child Safeguarding Practice Reviews – Appointing reviewers and agreeing methodology

The safeguarding partners are responsible for commissioning and supervising reviewers for local reviews[6].

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

Bexley S.H.I.E.L.D. intends to establish an approved list of suitably qualified and experienced independent lead reviewers on whom it can draw to undertake reviews. The establishment of an approved list will enable the partnership to commission independent reviewers with a minimum of delay following the Rapid Review meeting.

Review methodology

[6] Safeguarding partners may also consider appointing reviewers from the Child Safeguarding Practice Review Panel's pool of reviewers where available.

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 review. The methodology should provide a 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 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.

Family / practitioner involvement

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[7]. Families and children should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. It is expected that the family will be involved in the planning from the start and kept informed throughout the process.
- A communications plan for the family including the mechanisms for updates should be agreed at the start of the review to ensure everyone is clear about how to communicate progress to the family, including direct and indirect contact and who in the family needs to be involved. A template letter to the family is attached at **Appendix 10**.

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 and the guidance prepared by the Crown Prosecution Service, Association of Chief Police Officers and the ADCS covering the parallel conduct of Serious Case Reviews and criminal proceedings [INSERT LINK] remains relevant to child safeguarding practice reviews.

Final reports / Publication of Local Child Safeguarding Practice Reviews

The three 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.

[7] Morris, K., Brandon, M., and Tudor, P., (2013) 'Rights, Responsibilities and Pragmatic Practice: Family participation in Case Reviews'.

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 days8 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." (Paragraphs 36 – 42, Chapter 4, Working Together 2018)

In the Panel's opinion, a 'good' report is one that sets down:

- a brief overview of what happened and the key circumstances, background and
- context of the case. This should be concise but sufficient to understand the
- context for the learning and recommendations;
    - a summary of why relevant decisions by professionals were taken;
    - a critique of how agencies worked together and any shortcomings in this;
    - whether any shortcomings identified are features of practice in general;
    - what would need to be done differently to prevent harm occurring to a child in
- similar circumstances; and,
    - what needs to happen to ensure that agencies learn from this case.

(page 16, Child Safeguarding Practice Review Panel: practice guidance)

[8] 'Working day' means any day which is not a Saturday, Sunday or Bank Holiday.

2.5. Further information

Working Together to Safeguard Children (Department for Education, 2018)

Child Safeguarding Practice Review Panel: practice guidance (Child Safeguarding Practice Review Panel, April 2019)

London Child Protection Procedures (London Safeguarding Children Board, 2017 – due to be updated to take account of Working Together 2018)

Part 4	Serious Incident Process Grid

The process diagram below sets out the new arrangements for reporting an incident.

This process allows the Safeguarding Partnership to meet its obligations under the Working Together 2018 guidance regarding serious incidents for review within 15 days. The Safeguarding Partnership have a duty to notify the National Panel of their decision to complete a local review (or not) within this timescale.

Working Day(s)	Actions required	Lead
1	**Agency submits a Serious Child Safeguarding Incident Notification Form to Bexley S.H.I.E.L.D. (shield@bexley.gov.uk)**	
2 - 5	The Practice Review and Learning Manager or other member of the Safeguarding operations team will acknowledge the notification within one working day of receipt. On receipt, the Operations team will inform the 3 key partners and seek their initial views on whether the criteria for a serious incident is met. The Operations team will then notify the Learning from Practice Group and any professionals involved in the matter and arrange a Rapid Review meeting / or virtual rapid review. Requests for any background information (brief summary of involvement with the family / chronology of significant events) in preparation for Rapid Review. Information required within 3 days. Once received, operations team to collate initial information regarding agency involvement in the case and send composite to Learning from Practice Group in preparation for rapid review.	Practice Review and Learning Manager / Operations Team
6-10	Rapid Review meeting gathers facts, determines any immediate actions, next steps, recommendations to the S.H.I.E.L.D. Executive as to whether to undertake a child safeguarding practice review or not. Agree recommendation for type and approach of review. Safeguarding partners need to determine the response which is proportionate and likely to identify improvements in practice and protect children from harm.	Operations Team
10 -13	Produce briefing report (to include minutes and completed rapid review template) and notify S.H.I.E.L.D. Executive of recommendation (within 3 working days of rapid review meeting). If criteria is met and a formal review agreed, then notify National panel of outcome with rationale from Rapid Review. [N.B. Also need to notify them if the decision is not to undertake the review. All will depend on whether the criteria of a serious child safeguarding practice review case is met or not.] Recommendations to S.H.I.E.L.D. Executive	Practice Review and Learning Manager / Chair of Learning from Practice Group and Operations Team

	Chair of Learning from Practice Group, to report on and share with the S.H.I.E.L.D. Executive, including identification of any immediate or urgent actions for agencies (i.e.: members of the Learning from Practice Group).	
14-15	Report to the National Child Safeguarding Practice Review Panel. Rationale for review, proposed methodology. (The panel may share this with the DFE). Notification of rapid review decision to National Panel by Safeguarding Partnership operations team together with justification of decision (copied to nominated leads). Include rationale and suggested approach to review. If Serious Incident Criteria is not considered met but raises issues of importance for learning a referral into the Learning from Practice Group to be completed.	Practice Review and Learning Manager /Chair of Learning from Practice Group
Next Steps	National Panel decides and responds as to whether a Local or National Review is appropriate and/or confirms it agrees with outcome and recommendations of re Local Safeguarding Practice Review/rationale. Panel will take over oversight of review if National review agreed. If review to proceed as suggested by Partnership, then the following to be actioned and discussed with the Learning from Practice Group who will oversee review: • Identify reviewer if appropriate. • How the review will be approached? • Set down timescales • how the family will be involved	

Points to note:

- In absence of a nominated lead from a partner agency – then a nominated deputy will carry out the role.
- In absence of the Learning from Practice Group Chair, then a deputy representative will oversee the process
- Potential decisions for the Rapid Review are:
    - Local Child Safeguarding Practice Review – however recommending that the national panel take over the case as being of national importance.
    - Local Child Safeguarding Practice Review – no apparent national importance issues to recommend to the Panel.
    - Alternative local process e.g. Partnership Review (Could include multi-agency audit) Practice Learning Event may take place in any of the above approaches.
    - No further action.