Dealing with Serious Child Safeguarding Concerns

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Dealing with Serious Child Safeguarding Concerns

Contents:

1. Introduction

This guidance is for all BCP staff, managers, and senior leaders in relation to how to deal with serious child safeguarding concerns and sets out the arrangements in respect of the statutory partner agencies.

> *This guidance is written in the spirit of Working Together to Safeguard Children whose guiding principle is:*
>
> *'Everyone who works with children has a responsibility for keeping them safe. No single practitioner can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.'*
>
> *Para16 of Working Together to Safeguard Children, 2018*

This guidance brings together Working Together to Safeguard Children, published on the 5 July 2018 which replaced the previous guidance issued in 2015. The guidance was updated on the 21 February 2019 to reflect how local authorities should notify the **Child Safeguarding Practice Review Panel** and revised again on the 9th December 2020 to incorporate factual changes in relation to information sharing, homelessness duty and references to domestic abuse. A summary of the most recent changes can be found **here**.

Keeping Children Safe in Education revised and published on the 1 September 2020 and revised in September 2021, should be read alongside Working Together to Safeguard Children.

2. Governance

This process guidance has been ratified by the three statutory agencies named in Working Together 2018, i.e.

- The Local Authority – BCP Council Director of Children's Services,
- Dorset Clinical Commissioning Group (CCG), Director of Nursing, Quality/Strategic Safeguarding Lead, Dorset CCG
- Dorset Police, Assistant Chief Constables.

The statutory partners are accountable for the decisions made, are represented on the multi-agency Child Safeguarding Practice Review Group (CSPRG) and all processes are subject to scrutiny. The partners are responsible for ensuring that cases which meet the criteria for child safeguarding practice reviews have robust processes that meet the standards expected by the National Child Safeguarding Review Panel.

The named statutory partners take decisions on behalf of their organisation / agency and have power to commit resourcing, making policy, and holding their organisation to account, effecting, and implementing local changes.

Governance for these arrangements sit with the Child Safeguarding Practice Review Group (CSPRG), which is made up of senior representatives from Children's Services, Police and Health, with additional members from Public Health and the Youth Justice Service. The CSPRG has an independent chair who provides challenge and guidance to the partners. The chair is also responsible for ensuring that learning and key messages are reported to the PDSCP, and the partners are alert to thematic issues as well as examples of best practice.

The CSPRG is supported by the BCP PDSCP Business Unit. In addition to providing administrative support, the BCP PDSCP Business Manager is responsible for co-ordinating the review process, communicating with the National Panel and partners on any cases referred to CSPRG and leading on the dissemination of learning from child safeguarding practice reviews in the multiagency arena. Future developments for CSPRG will be to consider the development of reviews of cases that went well. This work will be developed with the Quality Assurance Group. The guidance will be reviewed annually or on publication from any further direction from the National Panel or relevant regulation or guidance in statute by the Secretary of State as stated in s22 of the Children and Social Work Act 2017.

This document sets out the local processes for conducting Rapid Reviews, including actions for cases that do not meet the criteria. The processes are informed by the National Panel's Practice Guidance, published April 2019, and draws from examples of best practice nationally.

3. Flowchart for Referrals to Child Safeguarding Practice Review Group

An LA must notify incidents to the National Panel where **abuse/neglect is suspected, if the child dies or suffers serious harm - in the LAs area or normally resident there and/or if a Looked After Child (LAC) dies.**

SERIOUS is defined by Ofsted as "significant or worrying because of possible danger or risk" but is a matter of judgement based on age, frequency of incident, injuries sustained, additional needs of child, context of home etc

Has the Local Authority decided to submit a Serious Incident Notification to Ofsted?

YES

Children's Services send SIN to BCP PDSCP Business Manager to circulate to CSPR partners with the Rapid Review Template.

Partners complete Rapid Review and submit prior to subsequent CSPR meeting. This should happen within 13 days, to allow time for collating responses prior to Rapid Review meeting.

BCP Business Unit collates returns for discussion at CSPR group on day 14

CSPR group considers Rapid Review against criteria by day 15. Contributing partners will be invited.

Rapid Review makes recommendation whether CSPR is required

Executive considers recommendation from the Rapid Review.

Business Manager notifies National Panel of recommendation from Executive. National Panel makes a decision regarding CSPR.

CSPR required

Commence commissioning arrangements for CSPR.

No CSPR Required

Ensure learning options are considered and outcomes are reported back to the CSPR Group.

NO

Relevant partner submits Safeguarding Practice Referral to CSPR group for discussion.

CSPR group agrees to request a Rapid Review?

YES

NO

Menu of learning options considered. Governance, timescales, and reporting arrangements agreed.

NB. If the recommendation is not agreed, the CSPR group Chair will take the challenge back to CSPR members and review the decision until an agreement is reached.

The Local Authority Duty & Responsibilities

The decision to submit a Serious Incident Notification (SIN) to the National Panel sits with the Local Authority. Working Together places a duty on Local Authorities to notify serious child safeguarding incidents.

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 (the 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.

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

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social, or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred, i.e., meets the criteria set out under Section 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017), which states:

Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if – (a) the child dies or is seriously harmed in the local authority's area, or (b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England. The LA also must notify secretary of state and Ofsted if a LAC child dies (reg 40 Children's Homes (England) Regs 2015).

This definition must be interpreted in a way which allows for the most serious incidents of abuse and neglect in all categories of harm to be identified and referred for consideration (this will include sexual abuse (which includes child sexual exploitation), neglect, physical and emotional abuse). Interpretation of the criteria must not exclude children or young people because of their age and the definition does not apply solely to children who have suffered severe physical injuries who have self-evidently suffered severe physical harm that is likely to affect their global development.

A referral must be made when a child has died or is seriously injured in a children's home (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.

The Children's Homes Regulations 2015, including quality standards guide provides examples of incidents that are likely to be considered serious. These include:

- a child being the victim or perpetrator of a serious assault
- a serious illness or accident

- a serious incident of self-harm 1 Alleged child perpetrators may also be the subject of a review if the definition of 'serious child safeguarding case' is met. 7

- serious concerns over a child's missing behaviour Serious illness or accident would include matters such as broken bones when a child loses consciousness or situations that require admittance to hospital for more than 24 hours.

Notification should consider and include cases:

- about the death of a child

- about the referral of someone working in the home to your Local Safeguarding Children Partnership

- if you know or suspect that a child has been involved in or subject to sexual exploitation (you should be able to provide evidence)

- about a serious incident with a child that required police involvement

- about an abuse allegation against the home or someone working there

- if a child protection enquiry has begun or finished If an SIN is submitted, Children's Services will immediately notify the BCP PDSCP Business Unit in order that a Rapid Review is triggered.

The local authority must notify the Panel of any event that meets the criteria within 5 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 5 working days.

The duty to notify serious child safeguarding events to the Panel rests with the local authority. Information on the process to be followed using the Child Incident Notification System can be found on **GOV.UK**.

The Child Safeguarding Practice Review Panel will share all notifications with the Department for Education (Secretary of State) and Ofsted. It is good practice for the Local Authority to do this directly.

Looked After Children:

For looked-after children, the Local Authority must notify the Child Safeguarding Practice Review of their death whether abuse or neglect is suspected. The Local Authority must do this within 5 working days of becoming aware of the incident.

The Panel will not consider the deaths of looked-after children where abuse or neglect is not known or suspected. DfE and Ofsted will take appropriate action in these cases.

The Local Authority must also notify:

- Local Safeguarding Children Partnership (LSCP)
- Local safeguarding partners

The Local Authority must do this within 5 working days of becoming aware of the incident and may want to notify LSCPs or local safeguarding partners outside of the area where appropriate.

If an SIN is submitted, Children's Services will immediately notify the NSCP Business Unit in order that a Rapid Review is triggered.

See Appendix D for The BCP Council process following notification of serious incident or death.

5. Using the child safeguarding incident notification system

The process for reporting a serious incident to the Panel via the Child Safeguarding Incident Notification System is set out in the following: **Report A Serious Child Safeguarding Incident (GOV.UK)**. The Panel will share all notifications with Ofsted and the DfE.

The Local authority must identify responsible persons to register for an account so they can make child safeguarding incident notifications. They should select **'child safeguarding notifier'** when registering for the system at - ChildSafeGuardingPortal (education.gov.uk)

If there are any concerns or the system is not working,
email mailbox.nationalreviewpanel@education.gov.uk with queries or request to make a manual notification.

The notifier must raise only 1 notification per incident, even if more than 1 child is affected. You can include:

- details of up to 4 children per incident
- further information, including details of other children involved

6. Referral to the BCP PDSCP Children's Safeguarding Partnership as a possible Serious Child Safeguarding Incident

In some cases, the Local Authority may not be required to submit a SIN, for example:

- complex medical needs cases
- children who are not known to/not active cases within Children's Services
- chronic neglect

In those cases, partners may still have legitimate concerns and there is learning for the multi-agency safeguarding partnership. If the senior manager or professional in a specialist safeguarding role believes that the circumstances of the child constitute a serious child safeguarding case, she/he must refer the circumstances to the BCP PDSCP Business Unit using the Safeguarding Practice Review Referral Form. It is good practice for agencies working with the child or family to jointly complete the referral to CSPRG. The BCP PDSCP Business Manager will ensure that the referral is put to the Safeguarding Practice Review Group for consideration on whether Children's Services need to submit an SIN to Ofsted and/or to proceed to a Rapid Review.

7. Rapid Review Process

In line with Working Together 2018, the aim of this Rapid Review is to enable safeguarding partners to:

- gather the facts about the case, as far as can be readily established.
- 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 & promote the welfare of children.
- decide what steps to take next, including whether to undertake a child safeguarding practice review.

BCP PDSCP will hold a Rapid Review of the circumstances surrounding a serious child safeguarding incident. The responsible officer for the agency is required to return a response in 15 days. The resource and capacity issues this involves, and this template is issued on the grounds that either

a. the case has met the criteria for the Local Authority to submit a Serious Incident Notification to Ofsted; or
b. (b)a partner has submitted compelling evidence that the case meets the criteria for a child safeguarding practice review using the Safeguarding Practice Review Referral.

The decision making to be recorded on the Rapid Review Record which includes whether immediate action is needed, the next steps and whether to recommend to undertake a Child Practice Safeguarding Review. The record is presented to the Executive for their consideration and final decision.

8. Lead Reviewer Commissioning

When a child safeguarding practice review has been commissioned, the PDSCP will appoint one or more suitable individuals as Lead Reviewers. The Lead Reviewers should be independent of the organisations involved in the case Prior to commission, the Lead Reviewer must demonstrate that they are qualified to conduct reviews.

At vetting, all Lead Reviewers are required to provide:

- contact details of two referees
- up-to-date CV, including previous experience of undertaking reviews, including any specialist knowledge/expertise that may be required
- details of any recent reviews conducted – ideally with links to published reports to review writing standards
- confirmation of public liability and professional indemnity insurance
- confirmation of registration with the Information Commissioner

Only high-level information on cases will be shared with the Lead Reviewer at initial discussion. Detailed information will not be provided until the above has been provided and a contract agreed.

The BCP PDSCP Business Manager offers clear guidance to reviewers to ensure that the review process includes the opportunity for reviewers to undertake reflective practice.

There is an expectation that the Lead Reviewer will create outcome focussed recommendations. The Lead Reviewer will clarify and differentiate between new learning as well as learning around assurance that existing policy and procedure is adhered to, or recommend that the statutory partners seek and provide assurance that existing policy and procedure is fit for purpose/robust and or if needs developing where required.

9. Roles and Responsibilities of CSPR Panel Members

The CSPR Panel members will:

- have sufficient seniority to be able to work at and represent all levels within their agency
- have had no significant involvement in the case under review
- be familiar with current child protection practice
- provide all information requested by the Lead Reviewer within prescribed timescales and in accordance with national guidance
- have unrestricted rights of enquiry and access to staff, records, and files
- ensure that all files relating to the child/the review are secured to ensure information is not lost
- ensure that the relevant staff in their agency are informed of the purpose of the child safeguarding practice review, and exercise their duty of care to staff involved, including communicating with them regarding expectations and their role in the process, the methodology agreed and the opportunities available for them to contribute to the learning
- participate in 1-2-1 meetings with any professional involved in the case, subject to methodology
- be fair in the way that the views of staff are represented
- advise the professionals involved, their agency and the Panel if any competency issues emerge because of the review and deal with this outside of the review process
- facilitate meetings with children and families, if appropriate to their role
- contribute to the analysis of practice and learning
- quality assure the draft reports prior to them being finalised for sign off

10. Involving Parents and Children in CSPRs

Family members are an important source of information about how services were experienced in an individual case and may provide information about service delivery in general. In this context, the definition of family can be broadened to include wider family and networks where this is judged to be necessary and proportionate to the likely learning. Publication of CSPRs places a greater onus on the BCP PDSCP to ensure that personal data placed in the public domain is accurate and involving family members may facilitate this. However, it can be entirely appropriate for family members to decide not to take part.

Families will be notified in writing and by telephone when a CSPR is commissioned with a clear explanation of the process, i.e., it is about learning not apportioning blaming and is an opportunity to better understand and improve safeguarding systems.

Family members will be offered the opportunity to speak directly with the independent Lead Reviewer as early in the process as possible, recognising potential constraints around any criminal investigations. Any evidence the family may wish to submit in terms of

correspondence or other written records they hold of service interventions should be treated with equal weight as the evidence provided by agencies.

Children and/or siblings will be communicated to via their support networks and/or through their allocated social worker. The Lead Reviewer will ensure that:

- The conversation is managed sensitively and in language that the child can understand and respond to
- Follow up care is arranged if the meeting causes additional distress.

The Lead Reviewer will be accompanied by a note taker, usually the NSCP Business Manager, to record the meeting. Notes will be shared with the family member to check for factual accuracy. Should there be a criminal investigation any such notes will be subject to review by the police disclosure officer to ensure compliance with the Criminal Procedure & Investigations Act 1996

One or more meetings may need to be arranged to ensure that the family is recognized as a key stakeholder in drawing out the learning.

Prior to the meeting(s) consideration will be given to:

- Identifying the support needed to enable child involvement
- Additional support needed where there are issues of domestic abuse
- Clarity about confidentiality especially if there is fear re repercussions from wider family/ network • Addressing any contradictory views between family members - especially if there are expectations about a definitive account 26
- Engaging with the senior investigating officer so they get the focus and scope of the review and rather than say no participation – allow informed discussion about how and when families can be involved the published reports will note:
- The purpose of family involvement, including which family members are involved and why
- How the analysis is informed by family members' knowledge and experiences relevant to the period under review
- Are there mechanisms to allow the family to feedback on the report before it is completed? The family will be advised of the publication date in advance and sent a hard copy of the final report for their records. If family members are not involved, the reasons for non-involvement will be noted in the report, e.g., they declined and/or were prohibited by parallel proceedings.

Sign off and Publication

Child Safeguarding Practice Review (CSPR) Report Sign Off The process for signing off CSPRs prior to publication involves three steps:

1. CSPR Panel agrees report is complete and reflects Panel discussions, prior to going to CSPRG
2. CSPRG agrees final report for sign off by NSCP
3. NSCP Partnership Group signs off the report at its bi-monthly meeting

The BCP PDSCP is led by the three statutory partners, i.e., the Local Authority, the Police and Health, and the meetings will also include strategic leaders from other areas of the partnership. When a CSPR is scheduled for sign off the head of any agency involved in the review will be invited to attend that meeting and agree the report prior to publication.

CSPR Report Publication

Child Safeguarding Practice Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond. Working Together 2018 requires local safeguarding partners to publish the final reports, unless they consider it inappropriate to do so. In such a circumstance, the partnership 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 will consider carefully how best to manage the impact of the publication on children, family members, practitioners and others closely affected by the case. The safeguarding partners will 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.

The Business Manager is responsible for sending a copy of the full report to the Panel and to the Secretary of State no later than five 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, the Business Manager will also provide a copy of that information to the National Panel, the Secretary of State and Ofsted within the same timescale.

BCP Council is the lead partner managing press statements, collaborating with relevant partner agencies. A separate briefing for Children's Services Lead Member is also prepared and issued by the Business Manager prior to publication.

11. Menu of Learning Options

This menu is intended to provide a framework for learning options in relation to cases considered by the Safeguarding Children Practice Review Group. This is not intended to be restrictive or definitive in terms of possible methodologies and may be added to or reviewed with time and experience. The methodology and type of learning model should be adopted to meet the specific learning potential for an individual case.

Type of learning	Rationale	Lead Officer	Timescale for completion	Methodology	Governance oversight
Local Child Safeguarding Practice Review	Meets statutory criteria	Independent Lead Reviewer BCP PDSCP Business Manager (supporting)	Six months	As required within Working Together 2018. Proportionate and using Systems approach to include: • Professionals • Families & children	PRG & BCP PDSCP Board
Multi-agency learning event	Learning for multi-agency partnership but does not meet CSPR criteria	To be agreed. Either: • Senior manager in partnership • LSCG Chair • Independent facilitator	Three months	One day event with TOR and lines of enquiry set by CSPRG, with Summary of Learning report produced at completion.	CSPRG & BCP PDSCP
Focussed Multi-Agency Case Review	Learning for multi-agency partnership but does not meet CSPR criteria. Where a need is identified for a greater degree of case analysis than is possible stand-alone multi-agency learning event.	To be agreed. Either: • Senior manager in partnership • Independent facilitator • LSCG Chair	3 – 6 months	As above: One day event and Summary of Learning Report, but with some limited/defined additional material/inquiries e.g.: • Issue/event specific Chronology •Document review • Meetings with staff • Meetings with families **Scope and focus to be clearly defined by CSPRG**	CSPRG & BCP PDSCP
Joint supervision	Key issue for consideration is way agencies are working together for cases that did not meet CSPR criteria	Independent supervisor identified in line with Joint Supervision agreement	4 – 6 weeks	One session Reference joint supervision policy and supporting docs	CSPRG
Single agency review or audit	Learning identified for single agency only	As identified by relevant agency.	To be identified by agency	In line with agency policy and practice	Governance is with Single Agency Lead.

12. Appendices:

Appendix A - Safeguarding Practice Review Referral Form
Appendix B - Rapid Review Template
Appendix C - The BCP Council process following notification of serious incident or death

Appendix A - Safeguarding Practice Review Referral Form

BCP Area Safeguarding Children Committee

Official: Sensitive

REQUEST FOR CONSIDERATION OF A CASE BY THE BCP AREA CHILD SAFEGUARDING PRACTICE REVIEW GROUP

Please complete and return to pandorsetsafeguardingchildrenpartnership@bcpcouncil.gov.uk after you have discussed the referral with the social worker and/or family.

(The referrer considers the case to potentially indicate - please tick as appropriate if you have a view on this)	
Child Safeguarding Practice Review	
Local Learning Review	
Multi-agency Case Audit	

Name of person requesting the Review	**Designation**	**Agency**

Name of family, family members, including dates of birth and addresses
Agencies Involved
Brief Family History
Detail why a Child Safeguarding Practice Review or Multi Agency Case Audit is considered to be appropriate – reference the guidance in Chapter 4 of Working Together to Safeguard Children 2018 to evidence your request

Person completing request Signed	**Print Name**	**Date**
Agency Safeguarding Lead	**Print Name**	**Date**

Please return to:
pandorsetsafeguardingchildrenpartnership@bcpcouncil.gov.uk

Appendix B - Rapid Review Template

RAPID REVIEW RECORD

Part 1

CHILD DETAILS	
Child's Name	
Gender	
Date of Birth	
Date of Serious Incident	
Location of Incident	

Part 2

PARENTS / CARERS DETAILS	
Mother's Name	
Date of Birth	
Parental Responsibility	
Father's Name	
Date of Birth	
Parental Responsibility	

MAIN CARER DETAILS IF CHILD IS LOOKED AFTER	
Name	
Date of Birth	
Caring Arrangement e.g., Private Fostering	

Part 3

GP DETAILS	
Practice Name	

Part 4

AGENCIES KNOWN TO BE INVOLVED IN THE CASE	

Part 5

CHARACTERISTICS OF THE CASE					
Domestic Abuse		Alcohol Abuse		Substance Misuse	
Mental Health (mother)		Young Parent		Teenage Pregnancy	
Sexual Abuse – allegation made by sister		Previously Looked After		Non-Accidental Injury	
Neglect		Exploitation		Learning Disabilities	
Emotional Abuse		Fabricated Induced Illness		More than One Child Abused	

Part 6

DETAILS OF RAPID REVIEW PANEL			
Date of Rapid Review Panel Meeting		Chair of Panel	

MEMBERS OF RAPID REVIEW PANEL	
Name	Agency

a) RELEVANT CASE HISTORY

b) IS THERE ANY IMMEDIATE ACTION NEEDED TO ENSURE THE CHILD'S SAFETY AND SHARE ANY IMMEDIATE LESSONS?

c) WHAT IS THE POTENTIAL FOR IDENTIFYING IMPROVEMENT TO SAFEGUARD AND PROMOTE THE WELFARE OF CHILDREN?

d) DECIDE THE NEXT STEPS INCLUDING WHETHER TO UNDERTAKE A CHILD SAFEGUARDING PRACTICE REVIEW	
DECISION TO RECOMMEND A LOCAL CHILD SAFEGUARDING PRACTICE REVIEW	
a) It was agreed that the case review meets the criteria for a Child Safeguarding Practice Review	Was met/was not met
b) WHY DOES THE CASE MEET/NOT MEET CRITERIA FOR A CHILD SAFEGUARDING PRACTICE REVIEW	
c) It was agreed that the case does meet the threshold criteria for a Child Safeguarding Practice Review, but we recommend this case should be considered as a National Review.	
d) **Set out the important complex issues that mean this case should be considered for a National Review**	
Was the recommendation unanimous?	
If no, reasons for dissent	

Part 7

SUBMISSION TO THE PAN-DORSET SAFEGUARDING CHILDREN PARTNERSHIP LEADERSHIP TEAM	
Signature of Rapid Review Chair:	
Date of submission:	
Submitted by:	
Contact for more information:	

PDSCP EXECUTIVE TEAM APPROVAL AND SIGN OFF

Part 8

DATE OF EXECUTIVE SIGN OFF MEETING
PDSCP Executive Team Attendees
Conclusions and final decision from Pan-Dorset Safeguarding Children Partnership Executive Team.

Appendix C - The BCP Council process following notification of serious incident or death

The BCP Council process following notification of serious incident or death

The child's social worker or, if not previously known to Children's Social Care, the duty worker receiving the information will:

a. Immediately inform their manager.

b. Obtain as much information as possible on the circumstances surrounding the cause of death / serious injury and pass this to the line manager.

The line manager will immediately inform the Service Manager by telephone and provide follow up information in writing as soon as possible afterwards.

The Service Manager will:

a. Inform the Service Director.

b. Ascertain as full details as possible from the Police and any other source.

c. Request their administrative staff to check Children's Social Care records on the note information held.

d. Restrict access to the file to Child's Social Worker, line Manager, Service Manager, Service Director, DCS and Quality Assurance Service Manager.

e. Arrange to inform the relevant agencies about the death / serious injury and remind them to secure their files.

f. Arrange to consider the circumstances of the death / serious injury, in accordance with BCP child protection procedures including the need to hold a Rapid Review and, where the child has died, a referral to the Child Death Overview Panel.

Local authorities should use the **Child Safeguarding Incident Notification System** to notify the Panel. The Panel will share all notifications with Ofsted and the DfE.

Death of, or Serious Injury, to a Looked After Child in Care

Where information comes to notice of the death of or serious injury to a child in care, the following tasks are required
The child's social worker will:

a. Immediately inform their line manager.

b. Notify the parent(s) immediately and in person, if possible.

c. In the event of a child's death, discuss with the parent(s) and reach agreement regarding the arrangements for the funeral (in the event of sudden, unexplained deaths arrangements for the funeral may need to be delayed).

d. In the event of a serious injury to the child, arrange with the parent(s) to visit the child in hospital.

e. Obtain as much information as possible on the circumstances surrounding the cause of death / serious injury and pass this to their line manager; and

f. Discuss with the line manager any necessary expenditure including reasonable travel expenses to assist the family in attending the funeral or visiting the child in hospital where it appears there is financial hardship.

g. Where the child was in a long-term foster placement, discuss with the line manager any possible conflict between the carers and the parents regarding arrangements for the child's funeral.

The line/team manager will:

a. Immediately inform the Service Manager by telephone and provide follow up information in writing as soon as possible afterwards.

b. Advise legal service initially by telephone, then confirm details in writing; and

c. Contact the Insurance Section of the Finance Department, initially by telephone and then in writing.

The Service Manager will:

a. Inform the Service Director.

b. Ensure that the parents' wishes concerning the funeral are discussed (by the social worker or the team manager), that any possible conflict with the wishes of the carers are also ascertained and addressed, and that any appropriate associated costs are met.

c. Consult the Service Director about the need for an internal management review of the case and if so, the appropriate person to conduct the review.

d. Where a review is to be conducted, collect any files held on the child and secure them

e. Arrange to inform relevant agencies about the death / serious injury and remind them to secure their files where a review is likely to be required.

f. Arrange, in consultation with the Quality Assurance Service Manager, appropriate meetings under the safeguarding procedures, including the need to hold a Rapid Review.

Additionally, whenever a Looked After Child dies, the local authority must inform the national Child Safeguarding Practice Review Panel within 5 days using the **Child Safeguarding Incident Notification System**. The Panel will share all notifications with Ofsted and the DfE. The local authority must also notify the Secretary of State and Ofsted where a Looked After Child has died, whether abuse or neglect is known or suspected.

Needs of Social Workers / Team / Managers / Carers.

During the implementation of this procedure consideration must be given to the needs of those staff and carers involved in the case.

The impact of a child death on social workers / team / manager / carer(s) to be addressed in terms of:

- The need for counselling for those involved.

- The way such support is offered.
- The provision of access to legal and professional advice about the ongoing conduct of the case.
- The provision of a clear explanation of the process of a rapid review or CSPR.
- Support for staff in the event of Police investigation / interviews.
- The need to inform and keep informed any relevant Trades Unions.
- The need for team debriefing whilst observing confidentiality. This must be discussed with the Service Manager.
- The need to acknowledge that a child death can impact on the productivity of any team and its ability to function; and the need to agree strategies to manage workloads