**Serious Incident Alert Process**

**LBTH Supporting Families Division**

Supporting Families may receive information regarding an incident involving a child/young person or an adult connected to them from a number of sources and for a number of reasons. These will not always be received in the form of a notification. The receiving social worker, manager or team should be able to use their judgement to recognise when an incident needs escalating and if in doubt, know who to contact for further advice.

This **Serious Incident Alert Process** aims to provide a quick reference guide to Supporting Families practitioners and managers.

The Serious Incident Alert Process **should be sent** to the Head of Service for Safeguarding & Quality Assurance **within 24 hours of the incident taking place**. The form needs to highlight the pertinent issues; nature of the injury, reason for the injury and impact of injury.

It should be noted that not all events and examples can be covered by this guidance due to the nature of individual cases/circumstance; however, the process will remain the same and does not distinguish between a victim and/or perpetrator of the incident. Particular attention should be given to incidents involving a child / young person we care for.

**What might trigger the serious incident alert process?**

* Death of a child or young person, including suicide or murder/manslaughter
* Attempted suicide
* Child or young person suffers serious injury inflicted either by themselves or others
* Rape / serious sexual assault
* Allegations against an adult (professional or carer) that is of a serious nature
* Cases identified through ‘gold group’ i.e., high profile cases
* Cases that might attract media attention
* Cases that pose a risk to the Council or Partner reputation

**Where might information come from to trigger the serious incident alert process?**

|  |  |
| --- | --- |
| * EDT
* MASH
* Early Help
* Young People’s Service
* Youth Justice
* Allocated social worker / team
* IRO / CIRO (who may also identify incidents retrospectively)
 | * MASE
* Child Death Overview Panel SPOC
* Other LA/Partner Agencies
* DfE / Ofsted
 |

On occasion, a multi-agency parallel process may be triggered first but this should still be treated as a source of notification – these can include:

* Domestic Homicide Review Process (Police led)
* Critical Incident Review Process (YJS led)
* Child Death Review Process (Health led)
* Serious Incident Review (Health led)
* Critical Incident Management Procedures (Education led)

**Who can I contact when in doubt or need further advice?**

**Geraldine O’Donnell** – Head of Service, Safeguarding & Quality Assurance (Supporting Families)

🕿 020 7364 6030

Email: geraldine.o’donnell@towerhamlets.gov.uk or SQA@towerhamlets.gov.uk

**Louise Griffiths –** Strategy and Partnership Manager THSCP

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Email: THSCP@towerhamlets.gov.uk

**What happens next:**

The Head of Service for Safeguarding & Quality Assurance, with the Director for Supporting Families will determine if the criteria for notification to the DfE is met.

***If the criteria for notification to the DfE is met*** the Head of Service for Safeguarding & Quality Assurance will make the notification using the DfE online child safeguarding incident notification system, within 5 days of the incident. In the absence of the Head of Service for SQA the Principle Social Worker will make the DfE Notification.

Following the DfE Notification being made the THSCP Business Unit convenes a Rapid Response Panel and requests Agency Checks be completed and returned. The Rapid Response Panel takes place within 10 days of the notification to the DfE being made. This case will then be known as a Statutory Review case.

***If the criteria for notification to the DfE is NOT met*** the SQA Service will complete a case review within 2 days of a Serious Incident Alert being sent to the SQA Service, to highlight if there are any pertinent issues that need immediate attention. A more detailed case review with happen within 5 days to consider our practice or if any lessons are to be learned. These case reviews will be known as “Need to Know” cases and the learning from the case reviews will be shared monthly with the statutory partners along with the learning from the Rapid Review Panels.

The learning from Rapid Review cases and “Need to Know” cases will be will be shared monthly with the THSCP Exec, SLT and the Managers Forum and any other multi agency forum.

The Head of Service for Safeguarding & Quality Assurance will acknowledge receipt of the Serious Incident Alert to the referring team and enter a case note entry on the child’s Mosaic record about the serious incident alert and outcome.

A spreadsheet is held by the Safeguarding and Quality Assurance Service which lists all the serious incident alert notifications.

**Supporting Families Serious Case Incident Alert Process**

**Incident reported to Supporting Families**

**Incident discussed with immediate line manager and Head of Service to be made aware**

**Safeguarding & Quality Assurance (S&QA) Head of Service notified**

**(Deputy: PSW)**

THSCP Business Unit Alerted (**use** Serious Case Incident Alert Form)

**Director – Supporting Families notified of Service**

**DCS alerted by Director Supporting Families**

THSCP Business Unit

convenes a Rapid Response Panel and requests Agency Checks be completed and returned

**Director and SQA Head of Service make joint decision if notifiable incident criteria met (WT18)**

Rapid Review Panel makes recommendation to THSCP Executive Partners if Child Safeguarding Practice Review (CSPR) criteria met

**SQA Head of Service Notifies DfE of serious incident within 5 days of incident**

**D/CSCMT informed of decision by S&QA Service Manager**

THSCP Executive Group makes final decision to initiate CSPR or agree an alternative approach

**Staff involved in case informed by relevant Head of Service and decision recorded on Mosaic**

THSCP Business Unit notifies DfE/National Panel of final decision within 15 days of SI notification to DfE

**Appendix 1 - Guidance on Serious Incident Notification**

**Notifiable Incidents Criteria**

**Duty on local authorities to notify incidents to the Child Safeguarding Practice Review Panel** (Working Together 2018, Chapter 4, page 84)

|  |
| --- |
| 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. |

12. The local authority must notify any event that meets the above criteria to the Panel76. 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 appropriate77) within five working days.

13. 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.

14. The duty to notify events to the Panel rests with the local authority. Others who have functions relating to children78 should inform the safeguarding partners of any incident which they think should be considered for a child safeguarding practice review. Contact details and notification forms for local authorities to notify incidents to the Panel are available from the notification to Ofsted page on Gov.uk79.

**Footnotes:**

76 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.

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

78 This means any person or organisation with statutory or official duties or responsibilities relating to children.

79 This form will be replaced in the future with a new notification system.

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**Agreed by: Children’s Social Care Management Team (CSCMT) on 14th December 2015**

**Version 6 February 2022**

**Supporting Families Serious Incident Alert Form**

**To be sent to the Safeguarding & Quality Assurance Service**

|  |  |
| --- | --- |
| **Notifier Details** **Name** **Agency** **Team** **(person completing the form)** |  |
| **Date** *(of Alert)* |  |
| **Reason for alert**  | * Death of a child or young person, including suicide or murder/manslaughter
* Attempted suicide
* Child or young person suffers serious injury inflicted either by themselves or others
* Rape / serious sexual assault
* Allegations against an adult (professional or carer) that is of a serious nature
* Cases identified through ‘gold group’ i.e., high profile cases
* Cases that might attract media attention
* Cases that pose a risk to the Council or Partner reputation
 |
| **Purpose for Alert** | For Information [ ]  For Action [ ]  Media Interest [ ]  |
| **What is the current status of the child / young person:**  | Child subject to a CP Plan Child in Need Child we care for UASC Early Help Youth Justice  |
| **Child Details** *(subject)**DOB****Mosaic*** *Legal Status**Address**Parent(s) Names* |  |
| **Sibling details** |  |
| **Date of Incident** |  |
| **Incident Details** |  |
| **Is the child known to other team / services?** **(Please outline / or ask other team to complete this section; YJS / Exploitation)**  |  |
| **Action Taken** **(Please include outline of safety planning for the child (and their family, if required))**  |  |
| **Decision(s):** | **Geraldine O’Donnell - Head of Service Safeguarding & Quality Assurance**  |
|  | [ ]  Serious Incident Notification Criteria Met / Not Met [ ]  Referral to THSCP Rapid Review Panel required [ ]  Other Action (stated below)  |
| **Response to Referrer** |  [ ]  Date:   |

Please Email Completed Alert Form to Head of Service: Safeguarding and Quality Assurance

SQA@towerhamlets.gov.uk

Geraldine.o’donnell@towerhamlets.gov.uk