Responding to Critical Incidents – Practice Guidance

Within Dudley Children's Services there are a number of reporting mechanisms for serious incidents or injury to children. These are:

- Children's Services critical incident notification form (internal process)
- National Panel Notification (to DfE)
- Children's Safeguarding Practice Review referral (to the DSPP)

Referrals to National Panel

Local Authorities have a duty to:

- Notify the national Child Safeguarding Practice Review Panel if a child dies or is seriously harmed in their area (or outside of England while they are normally resident in the local authority area) if it is known or suspected that the child has been abused or neglected.

- Notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected

Notifications must be made within 5 working days of becoming aware of the incident.

The Panel will share all notifications with:

- the Department for Education
- Ofsted

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 criteria for 'serious harm':

- Is the injury serious and/or will cause long term impairment?
- Was the injury caused by abuse or neglect?

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.

The criteria the National Panel will take into account include whether the case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
- raises or may raise issues requiring legislative change or changes to guidance issued under or further to any enactment
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children The Panel should also have regard to the following circumstances:
- significant harm or death to a child educated otherwise than at school
- where a child is seriously harmed or dies while in the care of a local authority, or while on (or recently removed from) a child protection plan
- cases which involve a range of types of abuse
- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings

Referrals for a Local CSPR (Child Safeguarding Practice Review)

Local CSPR can be a review conducted in any form deemed appropriate by the partnership. The Learning and improvement sub-group should decide what form of review is best suited and identify an author. A local CSPR could be conducted in the form of:

- A full CSPR with an independent author
- A CSPR with an author from within the partnership
- A table-top review
- A multi or single agency audit

The criteria which the local safeguarding partners must take into account include whether the case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children
- is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate.

Safeguarding partners should also have regard to the following circumstances:

- where the safeguarding partners have cause for concern about the actions of a single agency
- where there has been no agency involvement, and this gives the safeguarding partners cause for concern
- where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around
- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings

The Rapid Review

Rapid Reviews gather the facts of the case as quickly as possible to establish if any immediate action is needed to ensure a child's safety and the potential for practice learning. All agencies who have had involvement with the child or family are required to return an Initial Scoping template sent to them within 5 working days. The DSPP will review information submitted and make a decision regarding progression of the referral.

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

- gather the facts about the case, as far as they can be readily established at the time
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately
- consider the potential for identifying improvements to safeguard and promote the welfare of children
- decide what steps they should take next, including whether or not to undertake a child safeguarding practice review.

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

Dudley's Internal Processes for Reporting Serious Incidents

Operational Heads of Service are responsible for notifying the Head of Service Safeguarding of any critical incident that is likely to meet the criteria for a National Panel referral or a local CSPR immediately on receipt of the notification, using the Critical Incident Form. If by day 4 a decision has not been reached regarding whether the threshold is met for a referral to National Panel or a Rapid Review; then the Heads of Service will meet to discuss the circumstances of the incident and agree whether notifications are required. Information must be provided regarding the specific risk, immediate action taken to increase safety for the child and the views of partner agencies regarding the incident

The Head of Service for Safeguarding is responsible for completing the National Panel referrals and for sharing National Panel and CSPR referrals with the Director of Children's Services.

All three types of notification will be logged on a spreadsheet. This spreadsheet will be available for all SLT to access in the SLT share point. SLT will discuss critical incidents on a weekly basis to share updates regarding new notifications and share outcomes regarding action taken.

It is the responsibility of the HoS for Safeguarding for updating the spreadsheet when informed by the Head of Service for operational teams.

The HOS for operational teams will be notified of any referral for CSPR; so the allocated practitioner can be supported through the process.

It is the responsibility of the Head of Service Safeguarding to inform the Service Director for Children's Social Care, Director for Children's Services who will brief the Lead Member for Children's Services of all serious incidents notified to the National Panel and/or referred for a local CSPR.

Learning from Reviews

All child safeguarding practice reviews should:

- reflect the child's perspective and the family context
- be proportionate to the circumstances of the case
- focus on potential learning
- establish and explain the reasons why the events occurred as they did

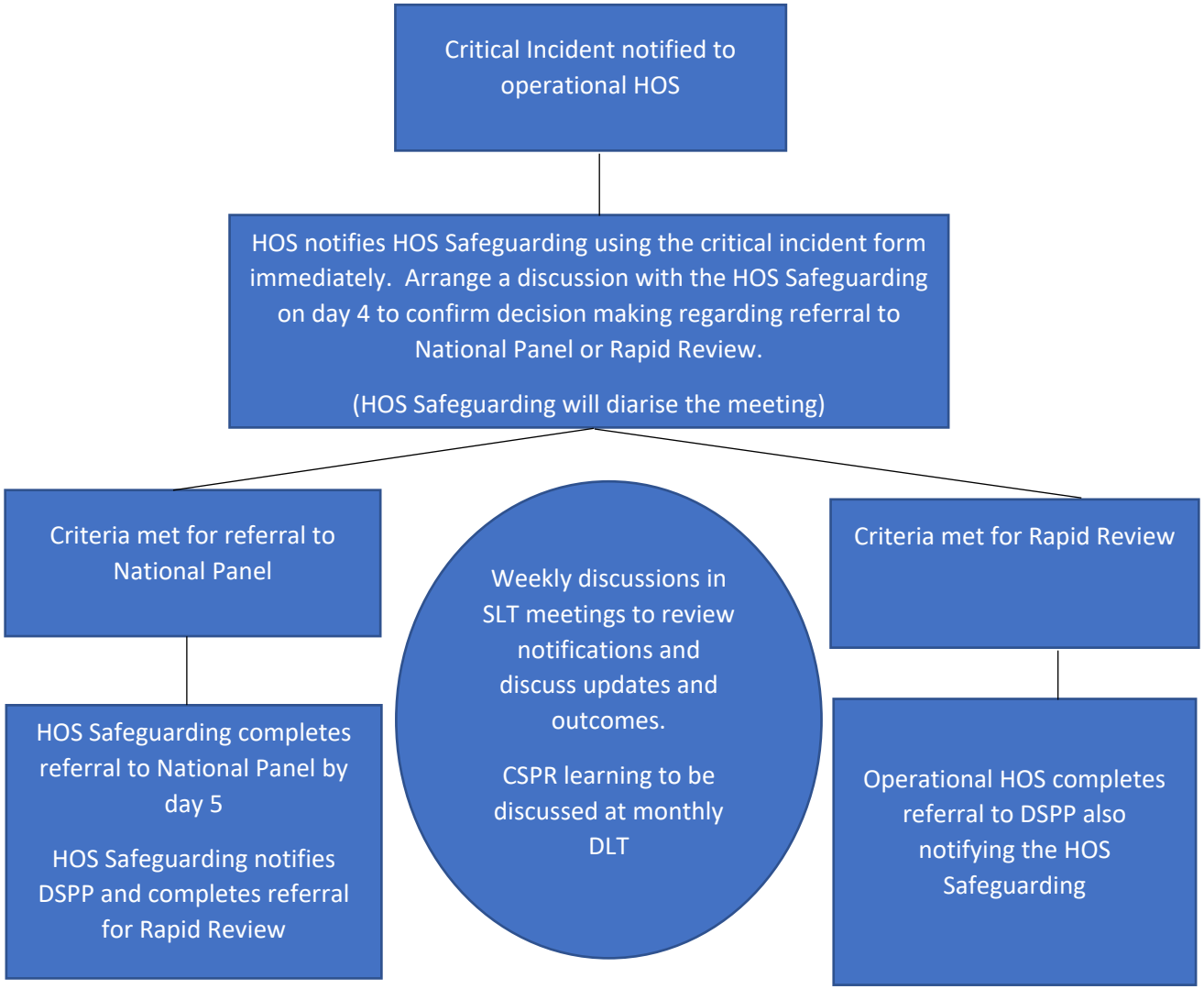
The Child Safeguarding Practice Review Panel regards a 'good' review report as one that includes:

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

Outcomes from CSPRs will inform thematic audits/training programmes and spotlights on practice within individual service areas. It is the expectation that all completed Local or National CSPRs are discussed within Extended DLT and learning disseminated through individual Team Development meetings.

Learning from CSPRs will be threaded through training events and procedural changes so practitioners are supported to embed practice changes that arise from critical incidents.

Flowchart


Critical Incident notified to operational HOS
HOS notifies HOS Safeguarding using the critical incident form immediately. Arrange a discussion with the HOS Safeguarding on day 4 to confirm decision making regarding referral to National Panel or Rapid Review.
(HOS Safeguarding will diarise the meeting)
Criteria met for referral to National Panel
HOS Safeguarding completes referral to National Panel by day 5
HOS Safeguarding notifies DSPP and completes referral for Rapid Review
Weekly discussions in SLT meetings to review notifications and discuss updates and outcomes.
CSPR learning to be discussed at monthly DLT
Criteria met for Rapid Review
Operational HOS completes referral to DSPP also notifying the HOS Safeguarding