# Child Safeguarding Practice Reviews in North Somerset

## NSSCP/001: FINAL: October 2020

### 1. Introduction

The Children and Social Work Act 2017 introduced a new legal framework in respect of local safeguarding arrangements for children. Responsibility for how a system learns lessons from serious child safeguarding incidents now rests at a national level with the Child Safeguarding Practice Review Panel and at a local level with the three Safeguarding Partners (clinical commissioning groups, police and local authorities).

Local areas will no longer conduct Serious Case Reviews. Instead we need to consider whether to conduct a Local Child Safeguarding Practice Review in cases where abuse or neglect of a child is known or suspected, and the child has been seriously harmed or has died

This document should be read in conjunction with Working Together 2018. Chapter 4, page 82 sets out the most up to date guidance and criteria for carrying out Child Safeguarding Practice Reviews.

### 2. Responsibilities

Locally, North Somerset Safeguarding Children Partnership are responsible for overseeing the review of serious child safeguarding cases which raise issues of importance in relation to North Somerset.

The Children's Partnership has established a Child Safeguarding Practice Review Subgroup which will manage and oversee the process of Child Safeguarding Practice Reviews (See Flow chart appendix 1)

The Child Safeguarding Practice Review Panel is responsible at a national level for overseeing the review of serious child safeguarding cases which in its view raise issues that are complex or of national importance.

### 3. The purpose of Child Safeguarding Practice Reviews

Reviews are not conducted to hold individuals, organisations or agencies to account Their aim is to prevent or reduce the risk of recurrence of similar incidents at both local and national level, and to identify improvements to be made to safeguard and promote the welfare of children

## 4. Definition for Child Safeguarding Practice Review

Working Together 2018 defines 'Serious child safeguarding cases' are those in which

- abuse or neglect of a child is known or suspected **and**
- the child has died or been seriously harmed.

Serious harm includes (but is not limited to) serious and/or long-term impairment of 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.'[1]

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

## 5. Duty on Local Authorities to notify incidents to the child safeguarding Practice Review Panel

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

'*Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if – (a) the child dies or is seriously harmed in the local authority's area, or (b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.*

*The local authority must notify any event that meets the above criteria to the Panel.[2] They should do so within five working days of becoming aware that the incident has occurred. The local authority should also report the event to the safeguarding partners in their area (and in other areas if appropriate[3]) within five working days.*

*The local authority must also notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected.*

*The duty to notify events to the Panel rests with the local authority. Others who have functions relating to children[4] should inform the safeguarding partners of any incident which they think should be considered for a child safeguarding practice review.'*

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[1] Serious harm is defined as under Working Together 2018 but further guidance from the National Review Panel and Avon and Somerset Safeguarding Strategic Partnership (ASSSP) will be sent out as an addendum shortly.

[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

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

[4] This means any person or organisation with statutory or official duties or responsibilities relating to children.

## 6. Criteria for a Local Child Safeguarding Practice Review

The North Somerset Child Safeguarding Practice Review subgroup will consider certain criteria and guidance when determining whether to carry out a Local Child Safeguarding Practice Review. They will take into account 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 that a local review may be more appropriate.

## 7. They will 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.

Meeting the criteria does not mean a local Child Safeguarding Practice Review must automatically be undertaken.

## 8. Making a referral to the Child Safeguarding Practice Review

8.1 If you become aware of a case which you believe fits the criteria for a Child Safeguarding Practice Review you should discuss this with your Team leader.

8.2 If it is agreed that the child meets the criteria referring to the Child Practice Review Panel, you must alert your service leader immediately, of the rationale for your decision.

8.3 Following agreement with your manager, it is essential you immediately:

Within the Local Authority

- Inform the Assistant Director, Support and Safeguarding
- Inform the Director People and Communities

Within the Police

- Major statutory crime review team (casereview@avonandsomerset.pnn.police.uk )

Within Health

- CCG safeguarding team (bnssg.safeguardingadmin@nhs.net)

8.4 Each agency can refer by email securely to NSSCP Co-ordinator (NorthSomersetSafeguardingChildrenPartnership@n-somerset.gov.uk) and Local Authority Service Leader (Strategic Safeguarding and QA,). They may ask you to complete a referral form, or supply additional information

**This needs to be done immediately, within one working day, of being aware that the incident took place**

**If there is disagreement between individuals, about whether to refer or not, please escalate to the Assistant Director for a decision**

**9. What happens next? (See attached Flow chart Appendix 1)**

The chair of the CSPR panel will convene the Child Safeguarding Practice Referral Subgroup to establish whether to carry out a Rapid Review and with which organisations **(Using the criteria set out above)**

**This must be done within five working days of the incident**

If a Rapid Review is undertaken:

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
- Learning identified is shared with agencies so that actions can be implemented where needed

**Rapid Reviews should be started within 5 working days of the decision to undertake it**

**Once started the Rapid Review must be completed within 15 working days**

As soon as the rapid review is complete, the safeguarding partners will send a copy to the National Panel.

They will also share with the national 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, the local authority service leader for Quality and Assurance will inform the Panel, Ofsted and DfE, including the name of any reviewer they have commissioned.

## 10. Local Child Safeguarding Practice Reviews

The review will 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. Reviews will reflect the child's perspective and the family context.

The methodology of a review will provide a way of looking at and analysing frontline practice as well as organisational structures and learning. It will be able to reach recommendations that will improve outcomes for children.

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

- **practitioners will be 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

It is important families understand how they are going to be involved and their expectations should be managed appropriately and sensitively

## 11. The final report

The final report will include

- 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 will be clear on what is required of relevant agencies and others collectively and individually, and by when, and focussed on improving outcomes for children.

Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond, so safeguarding partners will 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 appropriate to publish.

## 12. Flow chart: APPENDIX 1
## 13. Referral form: APPENDIX 2
## 14. Criteria: APPENDIX 2

## APPENDIX 1 FLOWCHART

Individual practitioner suspects a child or young person meets the criteria for a Child Safeguarding Practice Review (see criteria, Appendix 1)
Practitioner follows the guidance as set out in section 8, page 3 of this guidance

5 DAYS

**Individual completes a Child Safeguarding Practice Review (CSPR) Referral form and returns it securely to NSSCP Co-ordinator and Local Authority Service Leader (Strategic Safeguarding and QA)**
**This needs to be done immediately, within one working day, of being aware that the incident took place**
**NorthSomersetSafeguardingChildrenPartnership@n-somerset.gov.uk Service Leader notifies National Panel**

CSPR Sub-Group convenes to establish whether to recommend carrying out a Rapid Review and with which organisations.

NSSCP Executive is notified of sub-group decision.

NSSCP Co-ordinator circulate rapid review templates. Agencies complete and return within 10 working days.

CSPR sub group meet to review submissions and make a recommendation to NSSCP Executive to conduct a CSPR or alternative review. All this to be completed within 15 working days

Within one working day the National CSPR Panel notified of the outcome of the incident, and the commencement of a rapid review

**Agencies** secure their paper records

15 DAYS

Written submission to the National CSPR Panel within the original 15 working days to inform them of the recommendation.

National CSPR Panel meet to consider their response to the submission, and following this write to inform the Partnership of their decision.

National CSPR Panel decide to undertake a National practice review

National CSPR Panel decides a local review is needed

CSPR can only commence after this process is complete

Sub-Group Chair and Co-ordinator writes to inform the referrer and key agencies that a CSPR will commence

Actions led by the Sub-Group:

- ✓ Appoint a lead reviewer
- ✓ Agree who should form the Review Group to ensure that key organisations involved in the case are represented by a manager of sufficient seniority.
- ✓ Identify staff to be included in the Practitioner Group ie the staff and managers who were directly involved with the child and their family
- ✓ Inform family members about the review
- ✓ Draft Terms of Reference for the CSPR
- ✓ Agree template for chronologies

**CSPR Commences**

Completion of review should be within 6 months and a copy must be submitted to the National CSPR Panel prior to publication

# APPENDIX 2: Request for a Child Safeguarding Practice Review

Before submitting the referral please check the criteria in appendix 3 of this form. Once completed, please send this form to…..

1. Referrer

| | | | |
|---|---|---|---|
| Name: | | Email: | |
| Role: | | Tel: | |
| Agency: | | Date submitted: | |

2. Details of child or young person

| | | | |
|---|---|---|---|
| Name of child: | | Date of birth: | |
| Home address: | | Date of death or critical incident: | |
| Carer: | | Location of incident: | |

| **Ethnic origin:** | | |
|---|---|---|
| **(A) White** | **(B) Mixed** | **(C) Asian or Asian British** |
| ☐ British<br>☐ Irish<br>☐ Any other White Background | ☐ Asian and White<br>☐ Black African and White<br>☐ Black Caribbean and White<br>☐ Any other mixed background | ☐ Indian<br>☐ Pakistani<br>☐ Bangladeshi<br>☐ Chinese<br>☐ Any other Asian background |
| **(D) Black or Black British** | **(E) Other Ethnic Groups** | **(F) Not Declared** |
| ☐ Caribbean<br>☐ African<br>☐ Any other Black background | Please specify | ☐ Not Declared |

| | | | |
|---|---|---|---|
| **Faith:** | | **Disability:** | |

| | |
|---|---|
| **Child protection plan:** | ☐ Yes ☐ No ☐ Has been ☐ Not known |

## 3. Composition of family and significant others

| **Name** | **Relationship to child** | **DoB** | **Address** | **Ethnic origin** |
|---|---|---|---|---|
| **Add rows as needed** | | | | |

## 4. Rapid Review criteria

Please demonstrate how you believe the criteria for a Rapid Review to be met. The criteria can be found in **Appendix 1.**

| Criterion | Yes | no |
|---|---|---|
| Is the child deceased? | ☐ | ☐ |
| Is the child seriously harmed (please describe below)? | ☐ | ☐ |
| Is abuse or neglect known or suspected to be a cause of the death or harm to the child? | ☐ Known<br>☐ Suspected | ☐ |
| Is there a cause for concern as to the way in which agencies or other relevant persons have worked together to safeguard the child? | ☐ | ☐ |

## 5. Summary of events

Please provide a summary of the events leading to the death or harm caused to the child, making clear why you believe that these circumstances meet the criteria for SCR.

| |
|---|
| |

## 6. Other information

If you are aware of any other agencies involved in the care of this child please list below:

| Name | Agency | Contact details | Are they still involved? |
|---|---|---|---|
| Please add rows as needed | | | |

If you aware of any other processes that this case is currently subject to, ie. Coroner's inquest, Child Death Overview Panel, criminal proceedings, etc. please list below:

| Process | Current status |
|---|---|
| | |
| | |

# Appendix 3

## Criteria for referring cases to the NSSCP
## Statutory guidance from Working Together to Safeguard Children 2018

## Child Safeguarding Practice Reviews

The criteria described for a Child Safeguarding Practice Review in Chapter 4 are:

- Abuse or neglect is known or suspected AND
- The child has died or been seriously harmed

Serious harm[5] is described as including (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.

Meeting these criteria will not automatically mean a Safeguarding Practice review will occur, as the subgroup will 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. The subgroup may decide that a local or single agency review is more appropriate.

In all cases the following should be referred

- Any death of a child Looked After (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)
- Any death of a child in custody
- Any death of a child detained under mental health or mental capacity grounds

[5] Serious harm is defined as under Working Together 2018 but further guidance from the National Review Panel and Avon and Somerset Safeguarding Strategic Partnership (ASSSP) will be sent out as an addendum shortly.