Youth Justice Board
Bwrdd Cyfiawnder Ieuenctid

Community Safeguarding and Public Protection Incidents (CSPPI) – Standard Operating Procedures for Youth Offending Teams

Notification and Learning

Version 3
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Youth Justice Board

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Introduction

Who is this guidance for?

This guidance is for youth offending team (YOT) managers / staff (or equivalent colleagues responsible for the delivery and or monitoring of youth justice services in the community) and Youth Justice Board (YJB) personnel. It will also be of interest to local authority managers and other professionals involved in the safeguarding and protection of children.

What is the purpose of this guidance?

This document sets out what staff working in the youth justice system are expected to do in order to report information to the YJB if a child is involved in a safeguarding or public protection incident whilst under YOT supervision or on a YOT's caseload, or if they are charged with certain serious offences whilst not under YOT supervision or on a YOTs caseload. It does not replace any local or national safeguarding requirements or policies[1], but does offer advice and support to assist local services in identifying learning from incidents and improving practice as a result.

Why does the YJB need to know about safeguarding and public protection incidents?

The central piece of statutory guidance for safeguarding in England, Working Together to Safeguard Children (Department for Education, 2015 describes the need for agencies to safeguard and promote children's welfare, and offers the following definition of what it means to safeguard:

> "Safeguarding children and protecting them from harm is everyone's responsibility.- Safeguarding and promoting the welfare of children is defined as; protecting children from maltreatment; preventing impairment of children's health or development; ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and taking action to enable all children to have the best outcomes."

The 'Safeguarding Children - Working Together under the Children Act 2004' sets out the Welsh Government's guidance on child protection and safeguarding for local authorities in Wales.

The YJB has a statutory duty to monitor the youth justice system and share/promote good practice (Crime and Disorder Act 1998). Safeguarding principles as set out by Government are embedded in this aspect of our work. The YJB's approach to this is set out in our Supporting Safeguarding statement.

In order for the YJB to fulfil these statutory duties, these Community Safeguarding and Public Protection Incidents (CSPPI) procedures have been established to enable oversight of both serious safeguarding and public

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[1] Note also in National Standards, strategic standard 11 which states that those delivering statutory youth justice services must *'Establish and implement clear local policies and protocols in relation to public protection and risk management (including release and recall arrangements for young people on licence/supervision), and safeguarding and child protection which should take account of any existing local authority policies and thresholds'*

protection incidents in the community. For clarity, incidents within custody fall within the remit of the protocol for reporting serious and significant incidents 2009.

The YJB also needs to know promptly about any child who has been charged with certain serious offences, in order that preparations for the possible placement into custody can be made in good time, and any media enquiries dealt with swiftly with the least disruption to frontline services.

The YOT should record the young person's personal details on the CSPPI system within the Youth Justice Application Framework which will be linked to future YJB Placements records. All information recorded will be managed by the YJB in compliance with the Data Protection Act 1998.

The role of other organisations

When a child on the YOT caseload is involved (or is alleged to have been involved) in a safeguarding or public protection incident, it is important that any evaluation of the related circumstances takes account the interplay with any wider agencies and does not just focus on the role of the YOT. Services can include (but are not limited to) children's social care, education and health. The YJB advocates an approach to learning from serious incidents which focuses on the journey of the child rather than on the perspectives of individual service providers and therefore encourages joint working and learning wherever possible.

Identifying community safeguarding and public protection incidents

From 13 March 2017 the YJB has sought to streamline the CSPPI process. YOT representatives are now required to report the incidents or alleged incidents outlined in the table below. The list of safeguarding incidents have been aligned with requirements for both Serious Case Reviews (England) and Child Practice Reviews (Wales). The prescribed incidents should be notified to the YJB within 24 hours of a YOT becoming aware. It is the responsibility of the YOT to identify a safeguarding or public protection incident and when it needs to be reported to the YJB. However, if clarity is sought as to the categorisation of incidents and the application of the procedures then the YJB can be contacted for guidance.

YOTs must notify the YJB of a serious incident if a young person is:

- Charged with committing one of the following public protection offences, including those young people not under YOT supervision when they were charged.
- Involved in a safeguarding incident while on the YOT caseload or up to 20 calendar days following the end of YOT supervision.

The table below identifies the reportable incidents:

Safeguarding **Young person under YOT supervision / caseload (or within 20 calendar days of the end of YOT supervision):**	**Public Protection** **Young person (whether under YOT supervision / caseload or not) is charged with:**
Dies	Murder/Manslaughter
Attempts suicide (see Annex A)	Rape
Is the victim of rape (where an allegation has been made to the police)	A MAPPA serious further offence when the young person is already subject to MAPPA
Is the victim of sexual abuse/exploitation[2]	A Terrorism related offence (See Annex A)
Has sustained a potentially life threatening injury (See Annexes A and D)	
Has sustained serious and permanent impairment of health or development (See Annexes A and D)	

[2] For definitions of sexual abuse and sexual exploitation see Working together to safeguard children – a guide to inter-agency working to safeguard and promote the welfare of children, appendix A Glossary DfE 2015, definitions updated in February 2017

Young people on bail

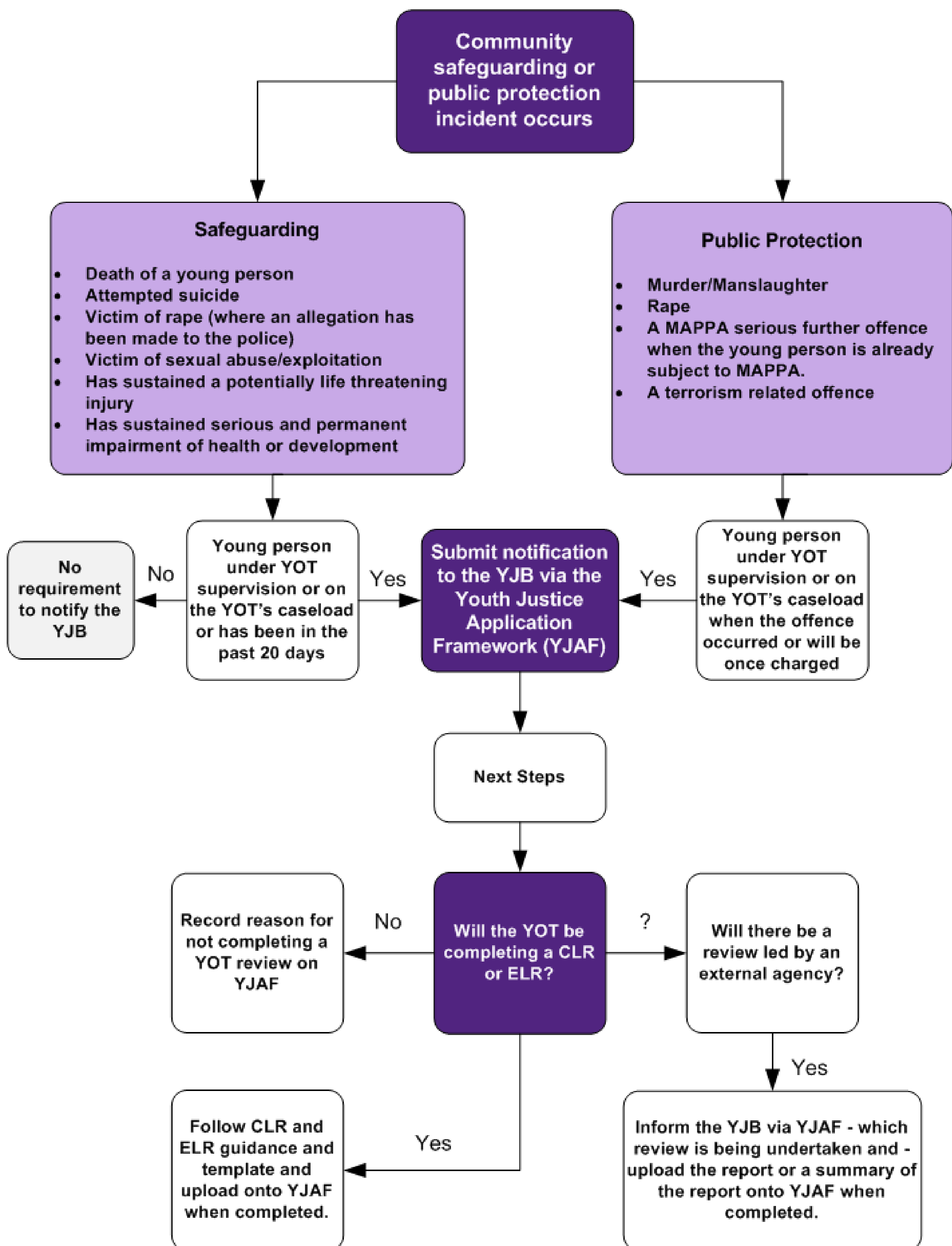
A notification should be submitted for young people who are on court bail which includes conditions stipulating YOT supervision i.e. Bail Support. Notifications will be relevant where the CSPPI notification criteria are met.

Young people engaged in early intervention services

A notification should be submitted for all young people who are subject to formal Out of Court Disposals i.e. youth cautions and youth conditional cautions involving YOT supervision, and where CSPPI notification criteria are met.

How to report an incident

The flow chart below is provided to enable YOT practitioners and managers to identify what and when to notify the YJB, with further details about the reporting process.


Community safeguarding or public protection incident occurs
Safeguarding
Death of a young person
Attempted suicide
Victim of rape (where an allegation has been made to the police)
Victim of sexual abuse/exploitation
Has sustained a potentially life threatening injury
Has sustained serious and permanent impairment of health or development
Public Protection
Murder/Manslaughter
Rape
A MAPPA serious further offence when the young person is already subject to MAPPA.
A terrorism related offence
No requirement to notify the YJB
No
Young person under YOT supervision or on the YOT's caseload or has been in the past 20 days
Yes
Submit notification to the YJB via the Youth Justice Application Framework (YJAF)
Yes
Young person under YOT supervision or on the YOT's caseload when the offence occurred or will be once charged
Next Steps
Record reason for not completing a YOT review on YJAF
No
Will the YOT be completing a CLR or ELR?
?
Will there be a review led by an external agency?
Yes
Follow CLR and ELR guidance and template and upload onto YJAF when completed.
Yes
Inform the YJB via YJAF - which review is being undertaken and - upload the report or a summary of the report onto YJAF when completed.

The Youth Justice Application Framework, a new community incident reporting platform, has been developed. YOT's are now required to use the Youth Justice Application Framework to report all notifiable incidents to the YJB. Specific technical guidance on how to access this system has been provided separately and can be found in the Youth Justice Application Framework document library.

In the event where there may be more than one YOT involved in the young person's case the expectation is that the completion of the CSPPI notification on the Youth Justice Application Framework will be the responsibility of the YOT that was delivering youth justice services to the young person at the time of the incident[3]. All relevant YOTs that have information to contribute should do so, co-ordinated by the notifying YOT.

When an incident has been identified as requiring notification to the YJB, the YOT will need to undertake the following steps:

1. **Ensure where relevant, that appropriate measures have been put in place to ensure safety and wellbeing of children, young people and adults effected by the incident.**
2. **Complete and submit the incident notification form on the YJ Application Framework.**
3. **Where necessary, discuss the case with a YJB staff member (normally your local partnership adviser or head of business area) and make an agreement about actions and timeframes for progressing the review of the case.**
4. **Record on the YJ Application Framework reporting system what report/s will be carried out and an anticipated publication date(s).**

In addition to reporting incidents to the YJB, the YOT Manager should inform the chair of the YOT Management Board of the incident and any subsequent reports via regular reporting within management board meetings. YOT Management Boards should also agree broader reporting arrangements with the local safeguarding children board (LSCB) to reflect local arrangements for risk management and learning. This might take the form of a quarterly or annual report and arrangements for the wider dissemination of learning from incidents or could be on a case by case basis, dependant on local arrangements.

Media enquiries and further information

Safeguarding and public protection incidents often attract media attention. YOTs should follow local procedures on handling media and also inform their assigned YJB Partnership Adviser where there is significant local or national interest.

[3] If the young person is charged with committing a public protection incident, including those young people not under YOT supervision when they were charged the YOT that will be supervising going forward will be required to report the incident

Reviewing incidents and identifying lessons

The YJB does not mandate that YOTs should complete any specific review following a safeguarding or public protection incident. Decisions about how and whether to review the circumstances around an incident or the services being delivered to children involved in incidents should be taken locally, following multi-agency discussions wherever appropriate, and with regard to any national requirements for reviews or investigations which may exist beyond the youth justice system. **The YJB is able to provide advice where necessary to support YOTs in considering which reviews would be most appropriate for the incident.**

If an external review of the incident is triggered e.g. Serious Case Review (SCR), Child Practice Reviews (Wales), MAPPA SCR or NHS Serious incident (see Annex D for further details), YOTs are required to update the CSPPI reporting system to indicate which review is being undertaken, the timescale for completion of this review, when that decision is made, and when the final report will be available.

Completed internal YOT review reports, external agency review reports or a summary of the report findings and actions, should be summited to the YJB by the YOT using the document upload facility within the appropriate incident case record on the Youth Justice Application Framework. The YJB **recommends** that a Critical Learning Review is conducted promptly after each incident so that key information and lessons can be captured and any necessary action taken, and as preparation for contributing to any external agency reviews. This is because external agency reviews can take an extended period to be commissioned and to eventually report findings.

The YJB has also developed an Extended Learning Review (ELR) tool which can be used in circumstances where there is no local arrangement for a detailed practice review.

Any review undertaken should be recorded on the Youth Justice Application Framework.

Critical Learning Review

A Critical Learning Review (CLR) offers an opportunity to rapidly capture initial learning following an incident. It allows early identification of any critical issues of concern and enables effective practice to be acknowledged and shared if appropriate. The CLR focuses on the immediate YOT led learning and should be used to record initial, informed observations and is not intended to be used in place of any local review or Extended Learning Review (ELR). See Annex B for further guidance on completing a CLR.

Extended Learning Review

The ELR template has been designed using a systems-based learning model to enable a detailed YOT led review of the case management and support

provided to a young person involved in a safeguarding or public protection incident. It is aligned with the approach advocated by Professor Munro[4] in her review of Child Protection, and with the approach being adopted in Wales as part of the framework for child practice reviews and provides a framework for the identification and dissemination of lessons. (See Annex C)

Which YOT should complete a review?

The YOT supervising the young person at the time of the incident should undertake the review. In the event where there may be more than one YOT involved in the case, the report should be completed by the YOT with day-today management of the case (host YOT[5]). However, the home[6] YOT (or any other YOT involved currently or recently in the young person's case) should be involved in the review, given sight of it and asked to provide input where possible. Where a child is Looked After and placed outside their home authority, the Local Authority who is the corporate parent should be fully involved in drawing together any lessons learned.

Sharing review findings

It is important that lessons learnt following serious incidents are shared so that actions can be taken to work to prevent similar incidents from happening in the future. The YJB welcomes and may in particular cases request sight of reports or of information about findings and recommendations, to inform its work to share lessons and practice examples, and to work with partner agencies to reduce the risk of future incidents and serious offences.

Learning from the young person

When reviewing incidents it is important to give the young people involved an opportunity to share their views about what happened and to work with them to identify and put in place the support and protective factors that will help keep them safe and prevent future incidents.

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[4] The Munro Review of Child Protection: Final Report A child-centred system Professor Eileen Munro (2011)

[5] Host YOT – refers to the YOT which provides services to the young person who does not normally reside within that YOT's geographical area.

[6] Home YOT – refers to the YOT where the young person normally resides or, in the case of a looked-after child, the YOT of the placing local authority.

Annex A – Identifying incidents – definitions and guidelines

Notification of a terrorism related offence

The number of under 18 year olds arrested for terrorism-related offences increased from 10 in the year ending December 2014, to 16 in the year ending December 2015. Though a very small proportion of all arrests of children, the recent figure was the highest number of terrorism-related arrests for this age group in a calendar year since the data collection began.[7]

A terrorist related offence covers those who have been convicted of:

- any offence under terrorist legislation
- an offence of conspiring, attempting, aiding, abetting, counselling, procuring or inciting an offence under terrorist legislation.

A terrorist related offence includes offences under terrorism legislation and other offences considered to be terrorism-related.

Terrorism is commonly defined as violent acts (or the threat of violent acts) intended to create fear (terror), perpetrated for an economic, religious, political, or ideological goal, and which deliberately target or disregard the safety of non-combatants (e.g., neutral military personnel or civilians).

Terrorism is defined in the Terrorism Act 2000 (TACT 2000) and means the use or threat of action where:

1. The action:

   a) involves serious violence against a person;

   b) involves serious damage to property;

   c) endangers a person's life, other than that of the person committing the action;

   d) creates a serious risk to the health or safety of the public or a section of the public, or

   e) is designed seriously to interfere with or seriously to disrupt an electronic system; **and**

2. the use or threat is designed to influence the government or to intimidate the public or a section of the public, **and**

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[7] https://www.gov.uk/government/publications/operation-of-police-powers-under-the-terrorism-act-2000-quarterly-update-to-december-2015/operation-of-police-powers-under-the-terrorism-act-2000-and-subsequent-legislation-arrests-outcomes-and-stop-and-search-great-britain-quarterly-u

3. the use or threat is made for the purpose of advancing a political, religious or ideological cause.
4. where the use or threat of action as defined above involves the use of firearms or explosives it is always terrorism, whether or not the condition in (2) above is satisfied.[8]

For further guidance on YOTs' role in preventing young people being drawn into terrorism see section 6 (3.7) of the YJB case management guidance '[Use community interventions: section 6 case management guidance']

Notification – young person has sustained a potentially life threatening injury

A 'potentially life-threatening injury' is one that in the view of medical opinion there is a substantial risk of death. These incidents are required to be reported so that the YJB are aware of any likely serious case reviews taking place which involve a young person under supervision or previously under supervision by a YOT.

The type of incidents which should be reported are:

All potentially life-threatening injuries sustained by a victim through the action of others for example:

- assaults involving offensive weapons, knives, bladed, pointed articles and other weapons (**all weapon inflected injuries should be reported as 'potentially life-threatening'**)
- serious physical assaults (without weapons).

All potentially life-threatening injuries sustained by a young person which were caused by:

- misadventure – e.g. drug overdose, joy riding
- risk taking anti-social behaviour.
- self-harm

Notification – young person has sustained serious and permanent impairment of health or development

The decision on whether a child or young person has sustained a permanent impairment of health or development will be defined by the clinical supervision team with medical responsibility. The medical team will identify if a substantial impairment of the function of a bodily member, organ, or mental faculty is likely to be permanent; or an obvious disfigurement that is likely to be permanent. This may be identified immediately at the time of the incident or may be defined a period of time after the incident occurred for example an injury to the head.

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[8] http://www.cps.gov.uk/publications/prosecution/ctd.html

YOTs should refer to their local Serious Case Review or Child Practice Review guidance for guidelines on defining a sustained or permanent impairment of health or development.

Guidelines on defining attempted suicide

An incident of ‘attempted suicide’ can be very difficult to identify, and risky self-harming behaviour where no intent to end life is apparent can be as dangerous as a concerted attempt at suicide. Defining these behaviours is not an exact science, but should be informed by assessments from health clinicians or local mental health professionals.

When considering whether a notification is required and whether there is learning to be gained from a case involving a suspected attempted suicide, practitioners and managers should consider past behaviours, the views of other professionals, the risk level of the young person involved, their thoughts and feelings (if it is possible to assess this at the point of notification) and the future risks of not reviewing the case.

Annex B – Critical Learning Review (CLR) guidance

What is a Critical Learning Review (CLR)?

A CLR offers an opportunity to promptly capture initial learning from an incident. It allows early identification of any critical issues of concern and enables good practice to be acknowledged and shared if appropriate. The CLR focuses on the immediate YOT led learning and may be used to record initial, informed observations.

When to complete a CLR

It is for YOTs to decide whether or not to conduct a CLR. If the decision is made to carry one out it is important to capture the initial learning without delay following an incident to help identify any key areas for action or improvement.

The CLR should be completed by an operational manager or a more senior manager. Where possible, the author should not have had direct management responsibility for the case. Consideration should also be given to creating a "peer review" arrangement with one or more YOTs where business conditions allow.

How to complete a CLR

The CLR template is downloadable via the document library in the YJ Application Framework. There is also advice on individual sections on the CLR form to further aid completion. It is expected that managers will routinely undertake a brief, prompt review of case management in the event of a safeguarding or public protection incident occurring. The CLR provides a framework for the findings of this review in the form of a short report which allows managers to record their findings.

Timescales

If the YOT decides that a CLR will be completed this should be done promptly to capture immediate incident information and identify risks and learning that require action. The template can be downloaded via the Youth Justice Application Framework.

Guidance on specific sections of the CLR template

Young Person's behaviour

This is an opportunity to reflect on any factors in the young person's life that could have helped to predict that the incident might occur. Consider whether any risks of harm had previously been identified. What was in place to manage the risk and protect the young person and/or the public? Did the incident being reported have links to any previous behaviour? Were there any unsubstantiated concerns about the young person's behaviour and how were they explored? Where appropriate the YOT should state what work has been done with the young person to understand their views of the incident and their behaviour.

Learning

What early lessons have been identified in the case? This is about identifying critical learning that could have implications to ways of working (systems) and needs an immediate response, or which would benefit from being shared to improve case management and the support provided to young people. It is not about finding fault in case management or practitioner delivery (this should be considered as a management issue outside the safeguarding and public protection review process). It is also not about detailed analysis or review, as this will be a considered process either in the form of the extended learning review or as part of a local (multi-agency) review.

Identify what change needs to and can be implemented at a local level, indicate whether it has wider implications (for example for other YOTs or agencies) and then state whether there are any concerns about national policies or guidance which have arisen from the early review of this case.

Good/Effective practice

It is important to recognise that the review of the case is likely to identify examples of good practice. Where this is the case it is important to acknowledge the impact it had. Are there benefits in sharing what you have found more widely? Is there potential to build on or expand the practice?

Quality Assurance

It is important that the critical learning review is subject to a level of independent scrutiny, which is proportionate to the context and sits in line with any further reviews which will take place. The YJB does not provide quality assurance as it is recognised that this is more effective if it is available within a local structure for delivering improvement and monitoring progress. This may come from a YOT Management Board, Local Safeguarding Children Board, MAPPA panel or through peer review where this is recognised by management structures.

Actions

It is key to any review process that findings and recommendations turn into actions which are monitored. Without this the learning will become obsolete and the review process will be undermined. In considering what actions are required, thought needs to be given to the measures of success which will be applied to them and the methods by which they will be monitored.

Annex C – Extended Learning Review (ELR) guidance

What is an Extended Learning Review (ELR)?

The ELR template has been designed to enable a detailed review, based on a systems model[9]of the case management and support provided to a young person involved in a safeguarding or public protection incident and is aligned with the approach advocated by Professor Munro in her review of Child Protection[10] .Where there is no local arrangement for a detailed practice review, the YJB ELR template can be used to structure a YOT led review and provide a framework for the identification and dissemination of learning.

When to complete an ELR

It is not intended that an ELR using the YJB template will take place *instead* of a Critical Learning Review or a detailed local review which meets the criteria for effective learning.

Examples of when an ELR using the YJB template may be used:

- Where a local review is not taking place but the YOT considers that there should be further learning drawn from the incident than can be ascertained through other approaches;
- Where there is a local review taking place but the YOT considers it is not sufficient and/or appropriate to produce the breadth or depth of learning needed.

How to complete an ELR

The ELR template is accessible via the documents library in the Youth Justice Application Framework Program along with the notification form and the CLR. There is also advice on individual sections on the ELR form to further aid completion. It is based on an assumption that the review will follow the child's journey, drawing on multi-agency practice to reflect fully on the lessons learnt and the potential for change. Like the CLR, the ELR can only be successful if 'next steps' are identified alongside measures of their success.

Timescales

The ELR template is designed to be completed within three months of an incident occurring but timescales should be set and agreed locally. Enough time should be allocated to allow consultation with other relevant agencies. Once the ELR has been completed it can be uploaded to the YJB for information via the Youth Justice Application Framework.

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[9] More information about an example of a systems based model for serious case reviews can be found here: http://www.scie.org.uk/publications/ataglance/ataglance01.asp

[10] The Munro Review of Child Protection: Final Report A child-centred system Professor Eileen Munro (2011)

Annex D – External Review guidance

Local Safeguarding Children's Board (LSCB) serious case review (England)

A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening in the future.

A SCR should take place if abuse or neglect is known or suspected: and either:

- a child has died; or
- a child has been 'seriously harmed[11]' and there are concerns about how organisations or professionals worked together to safeguard the child.

or:

- a child died in custody (including cases where abuse or neglect is **not** known or suspected.

The Local Safeguarding Children Board (LSCB) follows statutory guidance for conducting a serious case review.

The LSCB for the area in which the child is normally resident should decide whether an incident notified to them meets the criteria for a SCR. This decision should normally be made within one month of notification of the incident.

The LSCB must appoint one or more suitable individuals to lead the SCR who have demonstrated that they are qualified to conduct reviews using the approach set out in this guidance. The lead reviewer should be independent of the LSCB and the organisations involved in the case.

They should aim for completion of an SCR within six months of initiating it.

The final SCR report and the LSCB's response to the findings must be published on the LSCB website for a minimum of 12 months and should be available on request.

The LSCB is also responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by a **Child Death Overview Panel**. The objective of the death review process is not to allocate blame, but to learn lessons to help prevent further similar child deaths. Youth Offending Teams' reviews of safeguarding and public protection incidents (including the deaths of children under their supervision) should also feed into Child Death Overview Panel child death review processes.

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[11] 'Seriously Harmed' includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following: a potentially life-threatening injury; serious and / or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development. 'Working together to safeguard children' 2015.

Child Practice Reviews (CPR) (Wales)

A child practice review (CPR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons than can help prevent similar incidents from happening in the future.

A CPR should take place if child abuse is known or suspected and a child has:

- died
- sustained a potentially life threatening injury
- sustained a serious and permanent impairment of health or development.

The regional Safeguarding Children Board follows statutory guidance for conducting a CPR and there are two types of review:

- concise review
- extended review

The final report is approved by the Safeguarding Children Board and submitted to the Welsh Government and then published by the Safeguarding Children Board. It must appear on the Safeguarding Children Board website for a minimum of 12 weeks.

MAPPA Serious Case Review (SCR)

The purpose of the MAPPA Serious Case Review (SCR) is to examine whether the MAPPA arrangements were effectively applied and whether the agencies worked together to do all they reasonably could to manage effectively the risk of further offending in the community.

The aims of the MAPPA SCR will be to establish whether there are lessons to be learned, to identify them clearly, to decide how they will be acted upon, and, as a result, to inform the future development of MAPPA policies and procedures in order to protect the public better. It may also identify areas of good practice.

The Strategic Management Board (SMB) must commission a MAPPA SCR if **both** of the following conditions apply:

- The MAPPA offender (in any category) was being managed at level 2 or 3 when the offence was committed or at any time in the 28 days before the offence was committed.
- The offence is murder, attempted murder, manslaughter, rape, or attempted rape.

The report must not be widely distributed or published, and should only be shared with others on the authority of the SMB Chair. The timing of the report is crucial and its distribution may have to be delayed if it would have an adverse effect on any ongoing criminal proceedings. In cases of doubt, the SMB Chair should liaise with the Investigating Officer.

An Overview Report should be produced within one month of completion of the MAPPA SCR Report. The Overview Report should clearly identify which agency is responsible for delivering the Action Plan.

NHS serious incident investigations

The NHS serious incident framework seeks to support the NHS to ensure that robust systems are in place for reporting, investigating and responding to serious incidents so that lessons are learned and appropriate action taken to prevent future harm.

There is no definitive list of events/incidents that constitute a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents.

Serious incidents can be isolated, single events or multiple linked or unlinked events signalling systemic failures within a commissioning or health system.

The definition below sets out circumstances in which a serious incident must be declared. Every incident must be considered on a case-by-case basis using the description below

Serious Incidents in the NHS include acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

a unexpected or avoidable death of one or more people. This includes
   - suicide/self-inflicted death; and
   - homicide by a person in receipt of mental health care within the recent past

b unexpected or avoidable injury to one or more people that has resulted in serious harm;

c unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
   - the death of the service user; or
   - serious harm

d actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
   - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
   - abuse occurred during the provision of NHS-funded care.

   This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident

e a Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death.

f an incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

g failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues;

- property damage;
- security breach/concern

h incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;

i inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);

j systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services14); or

k activation of a Major Incident Plan (by provider, commissioner or relevant agency)

l major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation

Whilst the local authority will lead SCRs, SARs and initiate Safeguarding Enquiries, healthcare must be able to gain assurance that if a problem is identified, appropriate measures will be undertaken to protect individuals that remain at risk and ultimately to identify the contributory factors and the fundamental issues (in a timely and proportionate way) to minimise the risk of further harm and/or recurrence. The interface between the serious incident process and local safeguarding procedures must therefore be articulated in the local multi-agency safeguarding policies and protocols. Providers and commissioners must liaise regularly with the local authority safeguarding lead to ensure that there is a coherent multi-agency approach to investigating and responding to safeguarding concerns, which is agreed by relevant partners.

The YOT should make the decision if the local review is sufficient in meeting the investigative needs of this incident. The YJB is able to provide advice where necessary to support YOTs in reviewing what review/s would be most appropriate for the incident.