



Guidance for Identifying Serious Child Safeguarding Incidents and Undertaking Rapid Reviews and Local Child Safeguarding Practice Reviews

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GUIDANCE

1. Introduction

The guidance is for all Bournemouth, Christchurch and Poole (BCP) practitioners, managers, senior leaders, agency safeguarding leads and designated safeguarding leads in schools and colleges. It sets out the multi-agency process for dealing with serious child safeguarding incidents and undertaking Rapid Reviews and local Child Safeguarding Practice Reviews (CSPRS). The 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.'

This guidance brings together statutory guidance [Working Together to Safeguard Children](#) and the Child Safeguarding Practice Review Panel guidance which sets out how local authorities should notify the [Child Safeguarding Practice Review Panel](#).

The guidance should also be read alongside statutory guidance Keeping Children Safe in Education. [Keeping Children Safe in Education](#)

This guidance sets out local processes for identifying serious child safeguarding incidents, conducting Rapid Reviews, (including for cases that do not meet the criteria) and the process for undertaking local CSPRS. .

2. Governance

The guidance is produced on behalf of the Bournemouth, Christchurch and Poole (BCP) safeguarding partners¹ and is managed and reviewed by its CSPR subgroup.

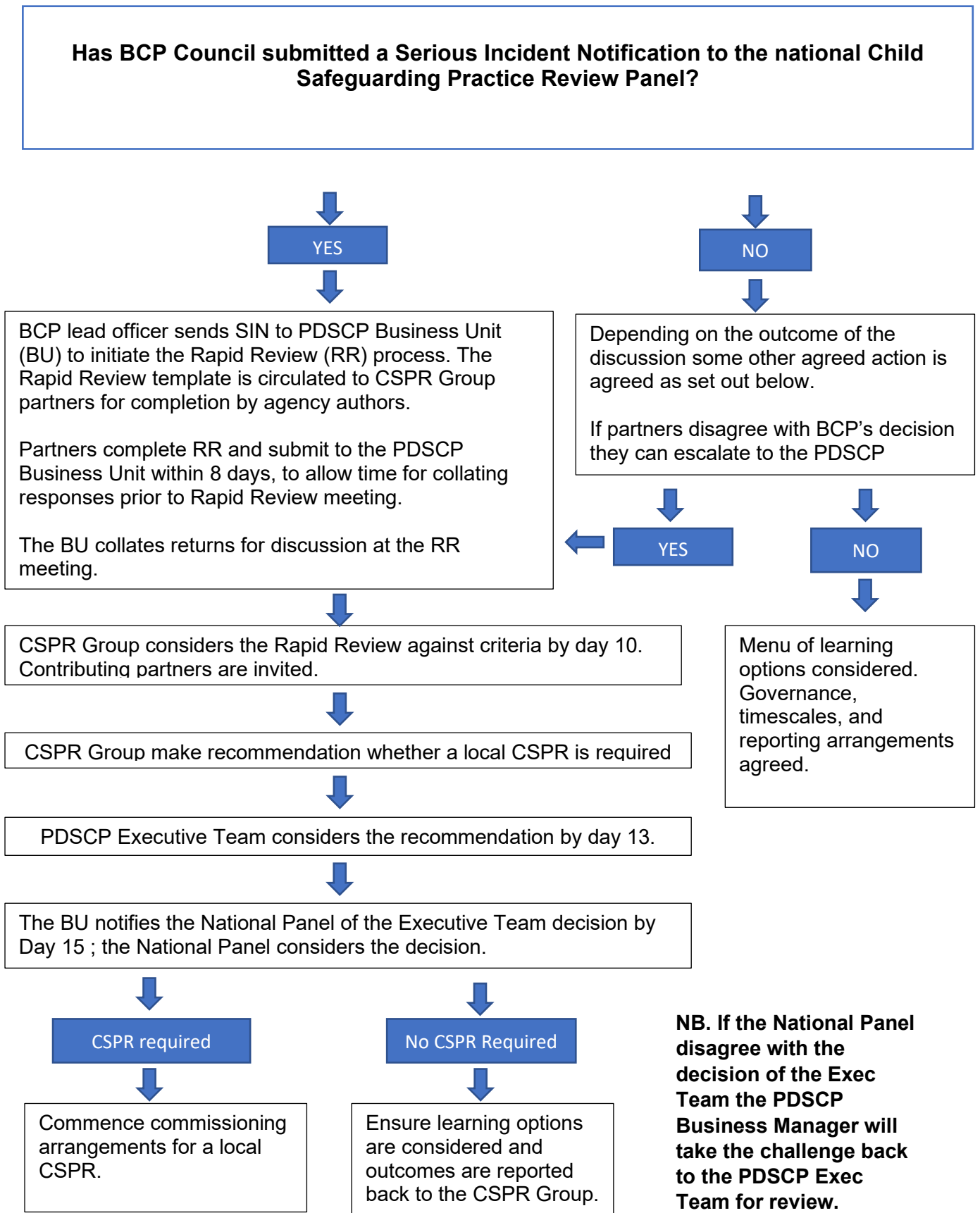
Statutory partners accountable for decision making are represented on the BCP Safeguarding Children Partnership (BCP SCP) and its CSPR subgroup. All processes are subject to robust review and scrutiny ensuring cases that meet the criteria as a serious child safeguarding incident are identified and subject to robust review.

3. Information sharing

The Pan Dorset Safeguarding Children Partnership (PDSCP) Information Sharing Agreement provides the legal framework to enable all relevant agencies under the Multi-agency Safeguarding Arrangements to share information legally and without the need for consent.

¹ BCP Council, NHS Dorset and Dorset Police

4. Flowchart for Serious Incident Notifications, Rapid Reviews and Local Child Safeguarding Practice Reviews



5. Serious Incident Notifications

Legislation and statutory guidance place a duty on Local Authorities to notify serious child safeguarding incidents. The decision to submit a child Serious Incident Notification (SIN) to the national Child Safeguarding Practice Review Panel (the Panel) sits with BCP Council².

BCP Council notifies 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 England³.
- c. BCP Council also notifies the Secretary of State and Ofsted if a Child in Care dies (reg 40 Children's Homes (England) Regs 2015).

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:

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 will always 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 considered serious.

BCP Council notifies the Panel of any incidents that meets the criteria within 5 working days of becoming aware that the incident has occurred.

BCP Council lead officer immediately notifies the PDSCP (Pan Dorset Safeguarding Children Partnership) Business Unit so that a Rapid Review is triggered and notifies the BCP SCP and the PDSCP Business Manager within 5 working days of becoming aware of the

² [Child Safeguarding Practice Review Panel guidance for safeguarding partners \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/guidance/child-safeguarding-practice-review-panel-guidance-for-safeguarding-partners)

³ 16C(1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017)

incident (and may also notify LSCPs or local safeguarding partners outside of the BCP area where appropriate).

For Children in Care who die, BCP Council will notify the Panel of the death within 5 working days of the incident whether abuse or neglect is suspected or not. The Panel will not consider the deaths of children in care where abuse or neglect is not known or suspected. DfE and Ofsted will take appropriate action in these cases.

Information on the process to be followed using the Serious Incident Notification System can be found on [GOV.UK](https://www.gov.uk).

The Panel will share all notifications with the Department for Education (Secretary of State) and Ofsted. It is good practice for BCP Council to do this directly.

(See Appendix B for The BCP Council process following notification of serious child safeguarding incident.)

6. Making a Serious Child Safeguarding Incident Notification

The process for reporting a serious incident to the Panel is 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.

All potential serious child safeguarding incidents identified in BCP Council must be brought to the attention of the BCP Head of Quality Assurance, Safeguarding and Partnerships who is the registered lead officer.

For all other partners, where an agency other than BCP Council becomes aware of an incident that meets the criteria for SIN, they should discuss this with the BCP Council lead officer (Head of Quality Assurance, Safeguarding and Partnerships) to reach an agreement on whether or not to notify. If both parties cannot agree upon a decision the partner agency must follow the PDSCP escalation process.

7. Rapid Review Process

If a SIN is made the CSPR Group will hold a Rapid Review meeting within 15 working days of the SIN.

The purpose of a 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.

Relevant partners are requested to complete a Rapid Review report template (Appendix B) and submit this to the PDSCP Business Unit within 13 days, to allow time for collating responses prior to Rapid Review meeting.

pandorsetsafeguardingchildrenpartnership@bcpcouncil.gov.uk

An integrated multi-agency Rapid Review report is presented to the PDSCP Executive Team with a recommendation on whether to undertake or not undertake a local CSPR.

The role of the Executive Team is to scrutinise the report decisions and recommendations, challenge partners and approve its sign off to be sent to the national Panel.

If the national Panel disagree with the decision of the Executive Team the PDSCP Business Manager takes the challenge back to them for review.

8. What is a Local Child Safeguarding Practice Review?

The purpose of a local CSPR is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.

CSPRs seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose but have a focus on learning.

Once a CSPR has been agreed the BCP CSPR Group sets up a dedicated panel to manage the review process through to its conclusion.

9. Panel Members Role and Responsibilities

The CSPR Panel members should:

- 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 independent 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 report prior to it being finalised for sign off

10. Commission of An Independent Local CSPR Reviewer

When a local CSPR has been agreed the PDSCP will appoint one or more suitable individuals as independent reviewers. The reviewers are independent of the organisations involved in the case and can demonstrate they are qualified to conduct reviews through a robust vetting process.

In all cases the BCP CSPR Group will consider whether the reviewer has:

- Sound professional knowledge and understanding of child safeguarding and practice relevant to local child safeguarding practice reviews
- The ability to engage both with practitioners, children, and families
- Knowledge and understanding of research relevant to children's safeguarding issues
- Ability to recognise the complex circumstances in which practitioners work together to safeguard children
- Ability to understand practice from the viewpoint of the individuals, organisations or agencies involved at the time rather than using hindsight • ability to communicate findings effectively
- Whether the reviewer has any real or perceived conflict of interest

All independent reviewers are required to provide:

- Contact details of two referees
- Up-to-date CV, including previous experience of undertaking reviews
- details of any recent reviews conducted – ideally with links to published reports to review writing standards
- Confirmation of public liability and professional indemnity insurance?

Detailed information will not be provided to the independent reviewer until the above has been provided and a contract agreed.

The independent reviewer agrees the review methodology with the CSPR Group, which will be reflective, outcome focused and differentiates new learning. They produce a local CSPR review report suitably anonymised for publication.

11. Involving Parents and Children

Children and family members are an important source of information about their lived experience of how services supported them and worked effectively together and will always be invited to contribute to a review.

Families are notified in writing and by telephone when a CSPR is commissioned with a clear explanation of the process and will be invited to speak directly with the independent reviewer as early in the process as possible, recognising potential constraints around any criminal investigations. Written evidence provided by the children and family is treated with the same equal weight as the evidence provided by agencies.

Children and/or siblings will be communicated with via their support networks and/or through their allocated social worker.

Any notes taken during the course of the conversations with the child and family are 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 and Investigations Act 1996.

12. Sign Off and Publication of the Local CSPR Report

Sign and publication off of the local CSPR final report involves four steps:

1. CSPR Panel agrees the report is complete and reflects Panel discussions and amendments prior to going to the CSPR Group for final approval
2. CSPR Group approve the final version
3. BCP SCP signs off the final report for publication
4. BCP SCP agrees a publication date and advises the PDSCP

Published reports will be publicly available for at least one year on the PDSCP website.

In preparation for publication of the report the safeguarding partners carefully consider how to best manage the impact of this children, family members, practitioners and others closely affected by the case. They ensure the report is completely anonymised to prevent identification of the child and family and the practitioners involved.

The PDSCP Business Manager sends 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 for managing press statements, collaborating with relevant partner agencies. A pre-publication briefing for Children's Services Lead Member, BCP Chief Executive Officer, Corporate Director of Children's Services. Media lead and all relevant safeguarding partners is prepared by the PDSCP Business Manager.

13. What Happens Next?

Once the final report is signed off the CSPR Group develop a multi-agency action plan, deriving from the review recommendations, and assign leads from their individual agencies to progress them. The action plan is monitored by the CSPR Group through to its completion.

On completion of the review action it is approved by the CSPR Group and signed off by the BCP SCP.

14. Embedding Learning

Reference Appendix A for a menu of learning options.

The learning from the CSPR and any recommendations will be translated into an action plan and presented to the CSPR Group. The PDSCP Business team will lead on this. The progress and impact of the action plan will be overseen by the CSPR group.

The Synopsis of Learning for a LCSPR/learning review will be formulated by the PDSCP Business Manager and should use the format of a 7-minute briefing - see example template from Warwickshire Partnership here [7-Minute Briefings \(safeguardingwarwickshire.co.uk\)](https://www.safeguardingwarwickshire.co.uk) - to make it easy and accessible for practitioners.

The Synopsis of Learning should then be presented to the CSPR sub-group for sign-off before this is then published on the PDSCP website.

15. Impact on Outcomes

The completed action plan is remitted into the BCP Quality Assurance Group (QAG) for follow up across agencies six months later to establish what impact the review has had on the quality of practice and systems. The QAG produces an impact statement to evidence what difference has been made.

16. Appendices

Appendix A: 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 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. Proportionate and using Systems approach to include: <ul style="list-style-type: none"> • Professionals • Families & children 	PRG & BCP PDSCP Board
Practitioner learning brief	Learning disseminated immediately	PDSCP (BCP) Co-ordinator	1 month	7-minute briefing on a page	PDSCP
Multi-agency learning event	Learning for multi-agency partnership but does not meet CSPR criteria	To be agreed. Either: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Senior manager in partnership • Independent facilitator • LSCG Chair 	3 – 6 months	As above: One day event and Summary of Learning Report, with some limited/defined additional material/inquiries e.g.: <ul style="list-style-type: none"> • 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.

Appendix B: Draft Rapid Review & CSPR template

Appendix C: 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 or not 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