BHR Safeguarding Partnership

Initiating a Child Safeguarding Practice Review (CSPR) or other Case Review

2020

Other documents making up this Protocol

1. Referral Form for Serious Incidents
2. Rapid Review Process & Timeline
3. Rapid Review Individual Agency Summary
4. Reviews not reaching the criteria for a CSPR
5. Case Review tracker – to be added
6. Child Death Review Process – to be added

1. Introduction

1.1. The Barking, Havering & Redbridge (BHR) Safeguarding Partnership is committed to supporting a mutual and reflective learning culture within and across all partners. We want to bring about changes that will lead to an improved practice system for children and families and a reduction in child abuse and neglect.

1.2. Historically our learning and our resources have been focused on safeguarding incidents that required formal statutory reviews. Whilst we will continue to learn from incidents in which children die or are seriously harmed, we will use the new freedom we have as a partnership to capture learning that is proportionate and meaningful rather than who did or did not do what and when.

1.3. Following a referral and consideration by a **Practice Review Group**, or similar multi-agency group we may recommend a review by the national Child Safeguarding Practice Review Panel, commission a local child safeguarding practice review, undertake a local multi or single agency learning review or consider whether a single or multi-agency audit might provide the most useful learning.

1.4. This operational protocol refers to all children and young people who are considered to be resident in the BHR area.

1.5. This protocol is made up of a suite of documents that together makes up the agreed working document for Barking and Dagenham, Havering and Redbridge as part of the Safeguarding Partnership across the BHR footprint.

2. What is a Serious Safeguarding Incident?

2.1. The identification of serious child safeguarding cases will primarily be through the notification requirements placed on the Local Authority which require incidents (set out below) to be notified to the Child Safeguarding Practice Review Panel.

2.2. **Section 16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) and Working Together to Safeguard Children (2018) 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 (the National 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

2.3. If any agency believes that a child has suffered significant harm due to abuse and neglect and meets the criteria for a referral to the Safeguarding Partnership they should

make a referral using the Referral-Form-for-serious-incidents as soon as possible after the serious incident occurs.

2.4. In a minority of these cases, these will be child deaths. It is important to recognise that the vast majority of child deaths are the consequence of medical or public health factors and very few relate to safeguarding. Whenever the death of a child is sudden with no apparent cause, a Joint Agency Response (JAR) in the hospital will look at the circumstances surrounding the death. If, after investigation, they have cause to believe that abuse is known or suspected the Chair of the JAR meeting should refer to the Partnership using the referral form.

2.5. All cases that meet the criteria **must** be referred to the National Child Safeguarding Practice Review Panel by the local authority within 5 working days using the online notification process. A copy of the notification will be provided to the Partnership Manager. Any organisation with statutory or official duties in relation to children (including those involved in the Child Death Review process) should inform the Safeguarding Partnership of any incident which they think should be considered for a child safeguarding practice review.

2.6. In addition, Safeguarding Partners at the local level must make arrangements to:

- identify child safeguarding cases which raise issues of importance in relation to the area

  and

- commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken

2.7. 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.

- recurrent themes in the safeguarding and promotion of the welfare of children.

- concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children; and

- a case that the Child Safeguarding Practice Review Panel has considered and concluded a local review may be more appropriate.

2.8. Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. It is for them to 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.

2.9. Safeguarding partners must consider the criteria and guidance set out at paragraphs 2.2 and 2.6 of this document, when determining whether to carry out a local child safeguarding practice review.

2.10. This document describes the process across BHR for discharging these arrangements when deciding to initiate a Child Safeguarding Practice Review or other action.

3. How a Recommendation/Decision will be made

3.1 To ensure that the Strategic Partners are supported to make the key decisions a recommendation will be made to them by the local **Practice Review Group** or similar multi-agency group.

3.2 Chaired by the Local Authority Head of Safeguarding or equivalent senior officer, this group will be made up of senior operational managers from the safeguarding partners who act as decision makers of their organisations.
Summary of functions:

- Undertake a 'Rapid Review' of cases in accordance with procedures set out in these arrangements Rapid Review Process
- Make recommendations about whether to undertake a CSPR and agree Rapid Review reports to the Strategic Safeguarding Partners
- Coordinate Learning Reviews

3.3 The Business Manager will be responsible for the process of any papers to enable this discussion and progress to Strategic Partners. All of this will be done on a pro-forma basis and may be done virtually. Records must be kept of every notification and its outcome.

Rapid Review Individual Agency Summary

3.4 Where a recommendation/decision is made that the criteria for a Child Safeguarding Practice Review (para 2.2) is met this should be referred to National Panel Child Safeguarding Practice Panel.

3.5 Where that criteria is not met, or ultimately the National Panel conclude that a local review may be more appropriate, this process is set out at section 4.

3. Notification Requirements

3.1 Any agency can inform the Safeguarding Partnership of an incident that they believe should be considered for a Case Review or other Practice Learning. To do so, the local referral form Referral-Form-for-serious-incidents should be completed and sent to the Multi-Agency Safeguarding Partnerships Manager

3.2 Where a looked after child has died this notification applies whether or not abuse is known or suspected. The 3 Safeguarding Partners (Local Authority, Police and CCG) must be notified within **five working days** as must the Secretary of State and Ofsted.

3.3 All notifications described above are to be coordinated through the respective BHR Local Authority.

4. When a Child Safeguarding Practice Review is not required – determining other local action

4.1 It is important that local action is determined using the same rigour as required for national reviews. Various types of local review may be used on a flexible basis according to the circumstances. Reviews not reaching CSPR criteria

4.2 The essential criteria for local action is:

i. Evidence of direct practice learning

ii. Working together or organisational challenges including both process and resource issues

iii. Policy development requirements or unclear or uncertain decision making

4.3 Types of review could include:

- a review or audit of practice conducted in one organisation, done jointly or independently.
- A local based case review approach using an 'independent' reviewer.
- A workshop/management review to flush out the key issues and learning using various methods including workshops, events, or summits.
- Links to other types of reviews e.g. LeDeR, Serious Incidents, Domestic Homicide Review could also be considered.
- A themed policy or practice review where core issues have been identified.

5. Links to Child Death Review (CDR)

5.1 Whatever approach is considered most appropriate, a recommendation should be made to the Strategic Partners as described in paragraph 2.2. The rationale for any recommendation should be carefully recorded.

5.2 As this approach develops it is crucially important that it is organised in conjunction with the new CDR arrangements, most particularly any learning and review activities that may emanate from the CDR process, namely Joint Agency Response (JAR) and Child Death Review Meeting (CDRM).

5.3 While the most usual referral would come from the Joint Agency Response (JAR) meeting, as the CDR arrangements develop it is important to review the referral mechanism to ensure best fit and consistent decision making.

5.4 It is also possible that themed reviews may be initiated as the Child Death Review' gathers momentum. It would be useful to extend this approach across the BHR/CDR footprint and adapt as required. It is important to ensure consistency across the Strategic Partners' span.

6. Reporting back and BHR Safeguarding Partnership involvement

6.1 The progress of all ongoing reviews or decisions about reviews will be reported as part of a tracker report to the local Strategic Partnership, the BHR Strategic Partners and the Independent Scrutineer for each partnership. This is to ensure no situations are lost and all are dealt with in a timely fashion.

7. Resolving disputes

7.1 Ultimately any dispute or concerns about the progress of practice development and learning based on this activity should be reported to the Strategic Partners.