GLOUCESTERSHIRE SAFEGUARDING CHILDREN PARTNERSHIP LOCAL CHILD SAFEGUARDING PRACTICE REVIEW (LCSPR) PROTOCOL

Summary: Under the statutory framework outlined in Working Together to Safeguard Children 2023, safeguarding partners—comprising the local authority, integrated care board (ICB), and police—are legally required to work together to identify and respond to serious child safeguarding cases. Where a child dies or is seriously harmed and abuse or neglect is known or suspected, partners must consider whether a Local Child Safeguarding Practice Review (LCSPR) is appropriate. This protocol supports Gloucestershire Safeguarding Children Partnership (GSCP) in fulfilling its legal duties by ensuring consistent, transparent, and effective practice across agencies.

Gloucestershire Safeguarding Children Partnership

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Version Control

Version	Date	Comment
1.0	Apr 2020	Executive Approved
1.1	Feb 2021	Changes to GSCP from GSCE. Revision to GSCP Structures and subgroups
1.2	Sept 2021	Inclusion of approved Multi Agency SIN decision process
1.3	Aug 2022	Updated ALTE definition, SIN Decision Info and GSCP logo
1.4	Dec 2023	Review, Amendment to SIN Decision Panel, Change of Logo
1.5	Feb 2024	WT 2023 Amendments - SIN Panel
1.6	Oct 2025	Revised National Panel Guidance[1] and local changes to SIN Panel Arrangements

Governance Note: This procedure is set out in line with the most current Working Together to Safeguard Children Guidance. Where it refers to Working Together it is considered to be referring to the current guidance[2].

[1] Child Safeguarding Practice Review Panel: guidance for safeguarding partners
[2] Working Together to Safeguard Children

1 Overview of Safeguarding Reviews within Gloucestershire

1.1 Introduction

This protocol is issued by the Gloucestershire Safeguarding Children Partnership (GSCP) and is grounded in the statutory guidance set out in Working Together to Safeguard Children. The protocol sets out clear expectations for how safeguarding partners in Gloucestershire should work together to identify, respond to, and learn from serious child safeguarding cases. Due to the complex and varied nature of safeguarding incidents, each review must be managed on a case-by-case basis. This document should be read in conjunction with the relevant national guidance referenced throughout.

It is intended to be read by all local safeguarding partners including; Gloucestershire County Council (GCC), Gloucestershire Integrated Care Board (ICB), Gloucestershire Constabulary, and other organisations with responsibilities for safeguarding and promoting the welfare of children.

It is particularly relevant to those working in education and childcare settings, as well as strategic leaders, senior managers, frontline practitioners, and individuals involved in Local Child Safeguarding Practice Reviews (LCSPRs), including reviewers, panel members, and those responsible for decision-making around whether a review is required.

Working Together to Safeguard Children sets out the role of safeguarding partners in establishing a robust, multi-agency system of learning and reflection at the local level. In Gloucestershire, the GSCP is committed to this principle, ensuring that when a child suffers serious harm or dies as a result of abuse or neglect—whether within the home, in the community, or online, partners work together to understand what happened and why.

This protocol supports safeguarding partners in Gloucestershire to fulfil their statutory duties by guiding the process for identifying, commissioning, and learning from an LCSPR. The aim is to reduce the risk of recurrence of similar incidents and strengthen safeguarding practice across all agencies.

Whilst it is important to understand why a specific incident occurred for the child at the centre of a review, the focus of system improvement must be on what the learning reveals about how agencies work together to safeguard children. In Gloucestershire, the GSCP adopts a systems methodology that builds on the reflections of individual agency roles and responsibilities and critically examines how well existing processes support effective multi-agency working.

This approach enables safeguarding partners to identify strengths, gaps, and opportunities for improvement across the wider safeguarding system—ensuring that learning leads to meaningful change and better outcomes for children.

1.2 Defining Serious Harm and Thresholds for Notification

In safeguarding, serious harm refers to significant or long-term damage to a child's mental, emotional, social, or behavioural development. It is a higher threshold than significant harm under the Children Act 1989 and applies to exceptional cases. When assessing whether to notify the Child Safeguarding Practice Review Panel, safeguarding partners must consider both the severity and context of the harm. Notification is required whenever abuse or neglect is known or suspected to have caused or contributed to a child's death or serious harm.

The GSCP recognises that not all children who experience serious harm where abuse or neglect is suspected will be known to, or receiving services, at the time of the incident, safeguarding partners must remain alert to these circumstances. These children should still be notified and a rapid review undertaken to identify learning for Gloucestershire.

Whilst the statutory duty to submit a Safeguarding Serious Incident Notification (SIN) lies with the Local Authority, Working Together to Safeguard Children introduces a strengthened expectation that the threshold for submission is determined collectively by the safeguarding partnership. In Gloucestershire, the GSCP Executive has agreed that decisions regarding whether an incident meets the threshold for a SIN will be made through a multi-agency SIN Panel. This ensures that all safeguarding partners—local authority, ICB, police, and others contribute to a shared understanding of the incident and its implications.

1.3 Partner Responsibilities for Raising Serious Incident Concerns

All safeguarding partners and relevant agencies in Gloucestershire are expected to notify the GSCP of any incident they believe may meet the threshold for an LCSPR. This should be done by submitting the approved SIN Consideration Form, available via the GSCP website[3] or directly from the GSCP Business Unit. This process ensures a consistent, transparent, and evidence-based approach to decision-making across the partnership.

The GSCP Business Manager and Business Unit play a key role in the quality assurance of all SIN notifications. They assess whether the information provided meets the threshold for a formal submission under Working Together to Safeguard Children 2023 and advise the GSCP SIN Panel accordingly where it is felt that the threshold has not been met.

The Business Manager, or Assistant Business Manager may advise the use of a more suitable process. Alternative processes provided below.

Child Death Review Incl. Acute Life-Threatening Event Review	MASH Contact	Allegations Management Contact	Escalation Procedure	Individual Agency Complaints Procedure

All deaths of children within Gloucestershire are reviewed by the Child Death Overview Panel. The Child Death process is not a child safeguarding process, but works with the GSCP closely

[3] consideration-of-a-sin-template-v1.3.docx

2.0 Safeguarding Practice Review Procedure

2.1 Governance and Responsibility of Safeguarding Review

The GSCP Business Unit manages the safeguarding review process, supported by the Quality and Improvement in Practice (QiiP) Subgroup. Strategic oversight is provided by the GSCP Management Group, with governance led by the QiiP Chair and GSCP Business Manager on behalf of the GSCP Executive. Progress and updates are reported quarterly through the Partnership Analysis Report, helping track reviews, identify trends, and coordinate subgroup activity. The QiiP and Management Group oversee outstanding actions and hold agencies to account. The action tracker is owned by partners and maintained by QiiP members.

2.2 Summary of LCSPR activity is divided into five areas:

Notification of a Serious Safeguarding Incident	Safeguarding Partners and relevant agencies should notify the SIN Panel of serious safeguarding incidents using the required SIN contact Form. The SIN Panel will determine if Threshold has been met.
Multi-Agency SIN Decision	The GSCP Multi Agency Serious Incident Notification (SIN) Panel will collectively consider all serious safeguarding cases against the threshold for a SIN.
Rapid Review	Where the SIN Panel has determined that a safeguarding incident meets threshold for a SIN the GSCP must commission a Rapid Review. Well-constructed rapid reviews can draw out significant learning that negates the need to proceed to an LCSPR.
Local Child Safeguarding Practice Review (LCSPR)	Where a Rapid Review considers a serious safeguarding incident requires a LCSPR it will make that recommendation in its report to the GSCP. An LCSPR should be commissioned.
Formal Publication of an LCSPR	Following the completion of an LCSPR, usually 6 months, formal sign off by the GSCP QiiP and Executive will be undertaken. The Executive must approve and sign off on all LCSPR publication Plans.

Full details of each step in the process are outlined below in Section 2.3 of this protocol.

2.3 Notification of a Serious Safeguarding Incident

Under Working Together to Safeguard Children, safeguarding partners must have a clear local process to identify, review, and respond to serious safeguarding incidents that may meet the threshold for a Local Child Safeguarding Practice Review (LCSPR).

In Gloucestershire, this process is led by the Multi-Agency SIN Panel, which determines whether a Rapid Review is required. To support consistent decision-making, all safeguarding partners and relevant agencies must notify the panel via the GSCP Business Unit[4] using the approved SIN Contact Form[5].

It is essential that all partners are familiar with the process and ensure the correct route is followed. The SIN Contact Form is designed to guide agencies through the required steps, so it is required that the form is used in its entirety. Forms that are incomplete or submitted for incidents that clearly do not meet the SIN threshold will be returned to the submitter with an explanation and advice on the appropriate process.

The GSCP Business Manager and Business Unit play a key role in quality assurance, reviewing all submissions to confirm that sufficient information has been provided and that the correct process is being applied. Once a submission is quality assured, the Business Unit will share the completed SIN Contact Form with the SIN Panel for formal consideration.

2.4 Multi-Agency SIN Decision

All incidents that may meet the threshold for a Serious Incident Notification (SIN) will be considered by the GSCP SIN Panel. As required by Working Together to Safeguard Children, the panel must include representatives from the Local Authority, Integrated Care Board (ICB), and Gloucestershire Constabulary.

In Gloucestershire, the SIN Panel also includes decision-making representatives from Education and the Gloucestershire Youth Justice Management Board, reflecting the partnership's commitment to inclusive and informed decision-making.

Health Representation in SIN Decision-Making: To ensure a consolidated health economy perspective and appropriate expertise, the ICB will consult with provider trusts regarding any incident under consideration. Where appropriate, the ICB may nominate a provider trust to represent the health position at the SIN Panel. The nominated trust will hold delegated authority to make SIN threshold decisions on behalf of the wider health system.

The Business Manager or Assistant Business Manager will be present to provide guidance on application of correct local policy and procedure. Section 1.2 references other processes for which the SIN panel may need to consider are more appropriate.

The SIN panel must review the circumstances against the threshold for a SIN, 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 (National Panel) if;

a) The child dies or is seriously harmed in the local authority's area, or

[4] GSCP@gloucestershire.gov.uk
[5] consideration-of-a-sin-template-v1.3.docx

b) While normally resident in the local authority's area, the child dies or is seriously harmed outside England. (This includes Wales)"

Within the context of safeguarding practice, serious harm refers to significant and/or long-term impairment of a child's mental health, intellectual, emotional, social, or behavioural development. This threshold is distinct from the definition of "significant harm" under the Children Act 1989, which may lead to child protection plans or care proceedings. While many children who suffer significant harm may experience lasting consequences, serious harm represents a higher threshold, reserved for exceptional incidents.

In assessing whether a case meets the criteria for notification to the Child Safeguarding Practice Review Panel, safeguarding partners must consider both the severity of the harm and the context in which it occurred. Notifications must always be made where abuse or neglect is known or suspected to have caused or contributed to a child's death or serious harm.

Further information and guidance are provided in the revised Child Safeguarding Practice Review Panel: Guidance for Safeguarding Partners.[6]

If the SIN panel decides that the circumstances have met the threshold for a SIN a Rapid Review will be commissioned, details of this process can be found in Section 2.6. At this stage the SIN panel should suggest the Key Lines of the enquiry and scope of the Rapid Review.

In the unusual circumstances where the SIN panel does not meet a unanimous decision following discussion, the Business Manager/Assistant Business Manager will refer the situation to the Chair of the Executive seeking direction to resolve professional disagreement.

Where the joint decision is that the incident does not meet threshold, usually this results in no further action but in some circumstances the SIN panel can request the QiiP consider if any other learning processes should be undertaken.

2.5 Submission of a Serious Incident Notifications

Working Together to Safeguard Children states that the local authority should notify the Panel within 5 working days of becoming aware that the incident has occurred. "The duty to notify serious incidents to the Panel sits with the local authority. When a notification is sent through the Child Safeguarding Online Notification System, a copy will automatically be sent to the Panel, DfE, and Ofsted."

Although it is the responsibility of the local authority to submit the SIN via the National Panel's platform the decision as to whether a situation has met the threshold for a SIN is a shared and equal duty between the safeguarding partners and is described above as the GSCP SIN Panel.

Responsibility for submitting a Safeguarding SIN lies with the GCC Children's Social Care (CSC) Area Directors (AD's), who must act on incidents involving children within their area. Each Area Director must ensure they have access to the Child Safeguarding Online Notification System and are able to complete the submission process promptly and accurately. The GSCP has developed a simple Guide for AD's which is available on the GSCP Tri-X portal[7]

[6] Child Safeguarding Practice Review Panel: guidance for safeguarding partners
[7] GSCP SIN Portal Guidance for AD's

The notification should be submitted via the Child safeguarding incident notification system[8]. For guidance on how to undertake this please refer to the Serious Incident Notification Guide for local authorities[9]. One notification is submitted per-incident irrelevant of the number of children involved. A copy of the submitted notification should be shared with the GSCP Business Unit for record keeping.

When the local authority submits a SIN the National Child Safeguarding Practice Review Panel will notify the Partnership of the obligation to conduct a Rapid Review. The Business Unit will proceed to follow this protocol and commission a Rapid Review on behalf of the GSCP Executive.

2.6 Rapid Review

A Rapid Review will bring together the most appropriate practitioners and professionals from across the partnership on a case-by-case basis. Generally, this will be the professionals who worked directly with the child(ren) and family. Professionals who have had no involvement with the child(ren) or family will not be asked to attend unless sufficient justification can be provided or for quoracy purposes.

In the main, but not always, Rapid Reviews will be chaired by an Independent Chair. The Independent Chair will be appointed by the Business Unit on behalf of the GSCP Executive.

The Rapid Review will be a written report capturing the discussion, analysis and final decision relating to the incident. Rapid Review reports should summarise the case, clearly state the concerns identified and recommendations for local and national learning. The report will also consider whether an LCSPR is needed and make recommendations accordingly.

Formal sign off from the SIN Panel is sought prior to submission to the National Child Safeguarding Practice Review Panel. By authorising the report, the SIN Panel members are approving the quality of report meets the requirements of Working Together, that the learning is proportionate and appropriate and as such approving the submission to the Nation Panel on behalf of the GSCP Executive.

The GSCP Business Manager / Assistant Business Manager will also be responsible for quality checking the report, recommendations and the decision to proceed to an LCSPR. If there is any professional disagreement the Business Unit will contact the Chair of the Executive for direction on resolution.

The Partnership must submit the Rapid Review Report via email (mailbox.nationalreviewpanel@education.gov.uk) to the National Panel within 15 working days calculated from the date the SIN notification was submitted to the panel.

Learning identified through Rapid Reviews must be shared across the Gloucestershire Safeguarding Children Partnership (GSCP) to support improvements in practice. All QiiP representatives are responsible for promoting and disseminating findings within their own agencies.

Anonymised Rapid Review Reports will be shared with the Rapid Review Panel and QiiP members, following feedback from the National Child Safeguarding Practice Review Panel. This ensures that learning is communicated effectively and informs both local and strategic safeguarding developments.

The Rapid Review Report will be shared by the Business Unit with the Regional OFSTED Lead for the South West once feedback from the National Panel has been provided.

[8] Child Safeguarding Portal
[9] Serious Incident Notification guide

Where a Rapid Review reports that a LCSPR is needed it is expected that the report will set out the reason for and what focus the LCSPR should take. Local Child Safeguarding Practice Reviews (LCSPRs) are designed to explore specific aspects of an incident where the Rapid Review has identified where there may be further learning to be gained from and LCSPR. These reviews aim to build on initial findings and provide a more comprehensive understanding of specific aspects for further learning which could not be obtained during a Rapid Review. It will not be a larger re-run of the Rapid Review

Roles are Responsibilities:

SIN Panel

- SIN Panel members must be of a sufficient seniority to be able to determine if the report accurately represents their agency and that identified learning, and actions can and will be achieved.
- Agreement that the recommendations are proportionate and relevant.
- The decision to proceed, or not to proceed, to an LCSPR is correct given the circumstances discussed within the report.

Independent Chair

- To confirm the Key Lines of Enquiry and scope of the review.
- To Chair the Rapid Review meeting.
- To author the Rapid Review report.
- To confirm during the meeting, and stipulate within the report, if the Partnership wishes to proceed to a LCSPR.

Professionals

- The Rapid Review should be attended by the most relevant professionals who can confidently discuss their agencies involvement with, and knows the child(ren).
- This is not a process to attribute blame or fault, it is to identify improvements in processes.
- Attendance at the Rapid Review meeting, this is mandatory.

Agencies

- To support the professionals who are attending the Rapid Review.
- Completion of an agency Involvement Form (AIF) from all agencies who worked with the child(ren). Submissions will be expected within 3 to 4 working days from request.

GSCP Business Unit

- Set and communicate a Rapid Review meeting date
- Appoint an Independent Chair.
- Share the SIN Panel's recommendations of Key Lines of Enquiry and scope of the review with the Independent Chair.
- Identify practitioners required to attend the Rapid Review Meeting.
- Request the completion of an Agency Involvement Form (AIF)
- Share AIF submissions with the Independent Chair.
- Provide administrative support during the Rapid Review meeting.
- The Business Manager or Assistant Business Manager will conduct a quality assurance review.

2.7 Local Child Safeguarding Practice Reviews

Purpose

Local Child Safeguarding Practice Reviews (LCSPRs) are not intended to be a repetition of the Rapid Review process. Rather, they should build upon the initial findings by focusing in on specific areas of concern or complexity that have been highlighted during the Rapid Review.

Safeguarding partners are collectively responsible for determining whether a serious incident meets the threshold for an LCSPR, in line with statutory criteria and guidance. The decision to commission a review should be made collaboratively, and there is no expectation that an LCSPR will automatically follow a Rapid Review.

The rationale for the decision—whether to proceed or not—must be clearly recorded and communicated through appropriate channels to ensure transparency and accountability.

The primary purpose of an LCSPR is to identify, analyse, and articulate key areas of learning arising from the incident, enabling the partnership to address practice issues and improve safeguarding outcomes for children and families.

Process

The Quality, Improvement in Practice Subgroup (QiiP) will determine the arrangements for each Local Child Safeguarding Practice Review (LCSPR) on a case-by-case basis, in accordance with Working Together to Safeguard Children. This approach ensures that reviews are tailored to the specific circumstances of each incident, rather than applying a standardised methodology across all cases.

Typically, an LCSPR Review Panel will be convened, comprising relevant safeguarding partners and chaired independently. The composition and structure of the Panel will be guided by the agreed scope and methodology of the review.

The primary role of the LCSPR Panel is to work collaboratively with the Lead Reviewer to deliver the review methodology and contribute to the development of the final LCSPR report. This includes supporting the identification, analysis, and articulation of key areas of learning arising from the incident.

In line with statutory guidance, LCSPRs are required to produce and publish a report that reflects the latest *Working Together* requirements. The purpose of the report is to enable the partnership to address practice issues and improve safeguarding outcomes for children and families.

Where a child's experience involves services delivered across more than one safeguarding partnership area, it is essential that the respective safeguarding partners liaise and agree which partnership will take the lead in conducting the Local Child Safeguarding Practice Review (LCSPR).

Ordinarily, the lead responsibility would fall to the safeguarding partnership in the area where the child is usually resident. This approach ensures clarity, consistency, and accountability in the review process, while also respecting the local context and relationships that may be critical to understanding the case.

Such decisions should be made collaboratively and documented appropriately, with clear communication between all involved partnerships to support transparency and effective coordination.

Safeguarding partners must ensure that both the review process and the final LCSPR report are fully aligned with the most up-to-date statutory guidance, including Working Together to Safeguard Children.[10]

Local Child Safeguarding Practice Reviews (LCSPRs) are intended to promote and share learning, both locally and nationally. Safeguarding partners must publish the final report, along with information about the improvements identified as a result of the review, in line with the most recent Working Together to Safeguard Children guidance.

The number of recommendations should be proportionate to the case; typically, more than 8–10 may hinder effective implementation. LCSPRs should, wherever possible, reflect the voice and experiences of the child.

Practitioner involvement is essential to ensure a broad range of perspectives and to incorporate relevant contextual evidence. The GSCP will involve practitioners in its LCSPRs while maintaining anonymity throughout the final report. The names of the Independent Chair and relevant agencies will be included where appropriate, provided this does not compromise practitioner confidentiality. The GSCP will take great care to manage this sensitively prior to publication.

Reports submitted to the National Panel must be the version intended for publication. The GSCP does not support producing a separate report only to redact its contents prior to release. This approach is considered unnecessarily bureaucratic and contrary to the spirit of transparency, learning, and improvement in safeguarding practice.

Sign Off & Governance of LCSPR's

All LCSPR reports and response plans must be submitted for quality assurance to the QiiP. QiiP members are responsible for ensuring that the first draft report and response plan are appropriately shared within their respective agencies and that senior management approval is obtained prior to submission to the GSCP Management Group and Executive for final sign-off and approval to publish.

The QiiP subgroup is accountable for ensuring:

- The report is ready for publication
- The response plan is being actively implemented
- All agencies have reviewed and signed off both the report and the response plan, including that all Communications Teams are aware and have notified relevant Elected Members and Governance Boards
- A clear and agreed publishing plan is in place across all safeguarding partners

All of the above must be completed before the report is submitted to the GSCP Executive with a formal recommendation to publish.

Publication and Embedding of Learning from LCSPRs

The GSCP Executive receives final LCSPR reports, response plans, and publication plans for multi-agency oversight and sign-off.

[10] CSPRP_guidance_for_safeguarding_partners.pdf

Under the direction of the GSCP Executive, the GSCP Business Unit coordinates the submission of reports and response plans. Reports are published on the GSCP website no sooner than seven days after submission to the National Panel, the Secretary of State, and Ofsted.

The Business Unit also manages the publication of links to the report, its findings, associated practice briefings, and relevant learning materials, forming part of the multi-agency post-review learning cascade.

The QiiP Subgroup is responsible for coordinating the implementation of learning and measuring its impact across all agencies. This includes findings from both Rapid Reviews and LCSPRs. Progress is reported quarterly to the GSCP Executive via the GSCP Management Group, using the GSCP Partnership Analysis Report.

All safeguarding partners are expected to ensure that learning is effectively cascaded and embedded within their organisations. This is monitored through Section 11 and other reporting mechanisms, providing assurance to the GSCP Executive of compliance and improvements in practice.

3.0 Other Areas for Consideration

3.1 Death of Looked-After Children

In accordance with Working Together to Safeguard Children and national guidance, local authorities must notify the Secretary of State for Education and Ofsted of the death of any looked-after child, regardless of whether abuse or neglect is known or suspected. This notification must be submitted within five working days of the authority becoming aware of the incident, using the Child Safeguarding Online Notification[11] System and following the national guidance[12]

This requirement applies to all causes of death, however, unless abuse or neglect is known or suspected to have directly contributed to the child's death, these cases do not require a Rapid Review or Local Child Safeguarding Practice Review (LCSPR). While many looked-after children may have experienced abuse or neglect prior to entering care, this background alone does not necessitate a review unless it is linked to the incident

Where recent abuse, neglect, or exploitation (including criminal or sexual exploitation) is believed to be a contributing factor to the child's death or serious harm, a Rapid Review must be undertaken to determine whether an LCSPR is required.

3.2 Notification Requirements for the Death of a Care Leaver

In line with national guidance and Working Together to Safeguard Children, Gloucestershire County Council must notify the Secretary of State for Education and Ofsted of the death of any care leaver up to and including the age of 24. This notification must be submitted via the Child Safeguarding Online Notification System within five working days of becoming aware of the incident.

While the death of a care leaver does not automatically trigger a Rapid Review or Local Child Safeguarding Practice Review (LCSPR), safeguarding partners within the GSCP must consider whether the criteria for a serious incident have been met.

[11] Report the death or serious harm of a child or care leaver - GOV.UK
[12] Serious Incident Notification Guide for local authorities

Where a serious safeguarding incident does not meet the threshold for a statutory review, but safeguarding partners believe there is valuable learning to be gained, the GSCP may choose to undertake an internal multi-agency learning review.

3.3 Children Placed Out of County (Including children placed in Gloucestershire)

Where a child's experience involves services delivered across more than one safeguarding partnership, or where a child has been placed out of county and a serious incident occurs, safeguarding partners must liaise and agree which partnership will lead the Local Child Safeguarding Practice Review (LCSPR).

Ordinarily, this responsibility lies with the safeguarding partnership in the area where the child is normally resident. A child in placement is considered to be in temporary accommodation, with their home authority remaining the nominal place of residency. Therefore:

- For children placed out of county by Gloucestershire, the GSCP would retain lead responsibility.
- For children placed in Gloucestershire by another authority, the placing authority would normally lead.
- The lead safeguarding partnership would be responsible for the submission of a SIN and any ongoing publication of an LCSPR. Only one SIN and one Rapid Review or LCSPR report is required in response to any incident

However, where safeguarding partners agree that the partnership in which the incident occurred is best placed to conduct the review, this arrangement may be adopted, provided it is clearly documented and mutually agreed. Funding of the review should be agreed at the time of decision as to which partnership is best placed to lead on the review.

3.4 Out of Country Incidents

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, where the child normally resides in Gloucestershire, dies or is seriously harmed outside England the local authority must notify the Child Safeguarding Practice Review Panel.

Gloucestershire boarders Wales, therefore, incidents occurring in Wales (or indeed any other country) where a child dies or is seriously harmed must be considered under this procedure as if the incident occurred in Gloucestershire.

Arrangements for the Submission of a SIN must be made in line with this procedure and within the defined timeframes, five working days from being aware of the incident.

The GSCP including the Gloucestershire Child Death Overview Panel will work with the appropriate local authority in which the incident occurred to consider the review arrangements to avoid duplication and may decide to either lead on any review or assist the local authority in which the incident occurred in their own arrangements.