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

February 2024

Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

Gloucestershire Safeguarding Children Partnership

Contents

Version Control

Revision	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

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[1].

[1] Working Together to Safeguard Children

Introduction

Under Working Together guidance the local Safeguarding Partners must have a process in place to identify, review and respond to serious safeguarding incidents that are referred to the partners for consideration of a Local Child Safeguarding Practice Review (LCSPR).

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

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

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.

The local authority must submit a Serious Incident Notification (SIN) for any event that meets the above criteria to the (National) Panel. They should do so within five working days of becoming aware that the incident has occurred. The local authority should also report the event to the safeguarding partners in their area (and in other areas if appropriate) within five working days.

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

WT 2023 sets out the duty for the Local Authority to notify the Secretary of State and Ofsted where a care leaver aged 18 up to 25 has died, where known. This is a separate process and is not covered in this Protocol.

Note: Whilst the duty for the submission of a Serious Incident Notification lies with the Local Authority, Working Together 2023 introduced the decision to determine threshold for the Submission of a Sin to be that of the Gloucestershire Safeguarding Children Partnership (GSCP) collectively. The GSCP Executive has agreed that the decision on threshold for a serious incident will be a multi-agency one, therefore this procedure also sets out the SIN decision making arrangements for the GSCP.

Others who have functions relating to children (any person or organisation with statutory or official duties or responsibilities relating to children) should inform the safeguarding partners of any incident which they think should be considered for a child safeguarding practice review and the submission of a SIN.

Safeguarding Practice Review Procedure

LCSPR activity within the GSCP is divided into five areas.

1) **Notification** - Safeguarding Partners notify cases which meet a Serious Incident Notification (SIN) threshold. In some circumstances a referral from the Child Death Review process may also require consideration for a SIN (Appendix 3)
2) **Multi Agency SIN Decision** - The GSCP will collectively consider all serious safeguarding cases against the threshold for a SIN.
3) **Rapid Review** – Where a safeguarding incident meets threshold for a SIN the GSCP must convene a Rapid Review. The Rapid Review assesses the case and provides a report to the GSCP via the QiiP. That report is submitted to the National Panel. A Rapid Review will bring together the most appropriate practitioners and professionals from the partnership on a case-by-case basis ensuring the right front-line professionals are in attendance. In the main, but not always, Rapid Reviews will be chaired by an independent Rapid Review Chair, as an element of their Independent Scrutiny Function, appointed by the Business Unit and approved by the QiiP. The Chair will produce the Rapid Review Report. The Rapid Review will assess the case and consider if a LCSPR is required.
4) **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 National Panel. Where a Rapid Review reports that a LCSPR is needed it is expected that the report will set out why and what focus the LCSPR should take. LCSPRs will look in detail at a specific aspect of the incident and should not be a larger rerun of the Rapid Review. An independent Chair can be appointed to oversee and lead the LCSPR and produce a formal report as required by Working Together guidance.
5) **Publication** – Following formal sign off by the GSCP QiiP and Executive the LCSPR Reports and Response Plans are sent to the National Panel seven working days prior to publication. The Executive must approve and sign off on all LCSPR publication Plans

The overall administration of the process sits with the GSCP Business Unit supported by the QiiP with Governance oversight from the GSCP Management Group. Overall responsibility for the process sits with the QiiP and its Chair supported by the GSCP Business Manager.

A safeguarding Review update report is provided to the GSCP Executive and the wider safeguarding partnership on a quarterly basis to ensure oversight and governance into ongoing reviews, identify trends, and determine priorities co-ordinating activity of subgroups to complete necessary development.

GSCP QiiP and Management Group provides governance for outstanding actions, holding agencies to account for delivery. Progress will form part of the regular updates reported to the Executive. Ownership of the tracker sits with the partners as delegated to the QiiP and its members.

Multi-Agency Notifications to the National Child Safeguarding Review Panel

Under Working Together guidance the local Safeguarding Partners must have a process in place to identify, review and respond to serious safeguarding incidents that are referred to the partners for consideration of a Local Child Safeguarding Practice Review (LCSPR).

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

Serious Harm Guidance 2020 - GOV.UK

The draft updated Panel Guidance July 2022 states: Is it serious? Often the judgement on whether the level of harm to a child is serious is quite straight forward. This may be because the child has a life-changing injury, long-term impairment resulting from an injury, or an injury that is clearly life-threatening, for example, requiring resuscitation or intensive care treatment. However, some incidents are not so clear and, in these circumstances, a judgement about seriousness is likely to be made. In cases of physical injury which are neither life-threatening, nor life-changing, consideration should be given to the extent, persistence and severity of the injuries sustained and any ongoing context of wider neglect or abuse. Isolated bruises or limb fractures in infants or children would not normally be considered serious unless accompanied by internal injuries (e.g. abusive head trauma, abdominal injuries) or are of a degree or extent likely to be life-threatening or life changing. In cases of sexual abuse, neglect or emotional abuse consideration should be given to the extent, persistence, and severity of the abuse, how this may have impacted on the child's development and well-being, and any likely long-term psychological harm, bearing in mind the child's development and any other contextual factors.

The OASys risk assessment tool: Defines "serious harm" as: "an event which is life threatening and/or traumatic and from which recovery, whether physical or psychological, can be expected to be "difficult or impossible".

The question posed in all SIN Decision Group discussions is whether a safeguarding incident notification should be submitted in respect of a child/ren and if the SIN Decision group feel that the child/ren suffered 'serious harm' as defined above.

Notification Process & Timescales

The local authority must submit a Serious Incident Notification (SIN) on behalf of the GSCP for any event that meets the above criteria to the (National) Panel. They should do so within five working days of becoming aware that the incident has occurred.

The Integrated Care Board, Constabulary and all relevant agencies will bring to the GSCP's attention any incidents that they feel meet threshold for notification promptly in order to meet the statutory timeframe of five working Days from being aware of the incident.

All notifications should be made to the GSCP Business Unit via email with the relevant detail to allow effective and prompt communication to the SIN Decision Group

Serious Incident Notifications

The statutory guidance on Serious Incident Notifications to the Child Safeguarding Practice Review Panel is set out in the Children Act 2004, 16C (1) (as amended by the Children and Social Work Act 2017).

The GSCP Executive, under its shared and equal duty to safeguard children, has determined that in Gloucestershire the following arrangements will form part of their Local Child Safeguarding Practice Review protocol and their Working Together published arrangements.

1. Responsibility for the submission of a Serious Incident Notification (SIN) rests with the local authority, however the Executive expect that any decision to submit a SIN has been discussed and agreed with statutory partners, the Constabulary and the Integrated Care Board, prior to submission as set out in Working Together to Safeguard Children Statutory Guidance.

2. The submission of a SIN initiates a Rapid Review notification from the National Panel. A Rapid Review must therefore be convened, and a Report sent to the National Panel within 15 working days from the date of notification from the National Panel to the partnership.

3. In order to support the Rapid Review process and to ensure oversight by the QiiP a copy of the SIN must be sent to the GSCP Business Unit at time of submission.

4. Where a case has been identified for notification the *QiiP Subgroup* statutory partners will respond promptly to a meeting request with the nominated SIN Lead/s for the Local Authority's Childrens Social Care and the GSCP Business Manager to discuss and collectively agree whether the incident meets threshold for a SIN.

5. All multi-agency decisions to submit a SIN will be communicated by the Business Manager or Assistant Business Manager to the QiiP Subgroup, who have the responsibility to oversee this protocols implementation, and the Independent Scrutineer.

6. Where a collective decision cannot be reached by the SIN Decision Group this will be escalated to the GSCP Executive by the Business Manager. The following applies in these circumstances.

7. The Local Authority holds the duty to submit a SIN on behalf of the Partnership. However, all decisions on threshold must be a multi-agency one and therefore the decision to submit in these circumstances becomes an Executive decision. In the event of a disagreement at the Executive level the incident must be referred to the Independent Scrutineer.

8. Where the joint decision is that the incident does not meet threshold, but the partners feel that the incident deserves a Multi-Agency Case / Thematic Audit can be requested. Arrangements for a referral to the GSCP QiiP Subgroup should be discussed at this point.

Note: The GSCP Executive accepts that circumstances will arise where an assessment of an incident may result in a difference of professional opinion but consider these to be the exception rather than the rule.

Note: 'Out of County', 'Out of Country' as well as responsibilities regards children placed in Gloucestershire by other local authorities can be found on page 21 and 22.

SIN Decision Group

Primary Quorate Members

- Integrated Care Board Designated Dr Child Safeguarding or Designated Nurse Child Safeguarding
- Gloucestershire Constabulary – Designated SIN Decision Maker
- Gloucestershire County Council Children's Social Care – Designated SIN Submission Officer/s

Additional Specialist Representation

- Gloucestershire Health & Care - Designated SIN Decision Maker
- Gloucestershire Hospitals - Designated SIN Decision Maker

GSCP Governance –

- Chair – Quality and Improvement in Practice (QiiP)
- GSCP Business Unit Business Manager or Assistant Business Manager
- GSCP Management Group

Rapid Review

When the partnership submits a SIN, the National Panel will notify the Partnership of the obligation to conduct a Rapid Review to consider the incident and determine if it may require a Local Safeguarding Practice Review. The GSCP must report on the Rapid Reviews findings back to the National Panel within 15 working days of their notification.

The aim of a Rapid Review is to:

- gather the facts about the case, as far as they can be readily established at the time.
- discuss whether there is any immediate action needed to ensure children's safety.
- consider the potential for identifying improvements to safeguard and promote the welfare of children.
- decide what steps the GSCP should take next, including whether to commission an LCSPR.
- submit a report to the National Child Safeguarding Practice Review Panel outlining the above

The GSCP through the QiiP Subgroup will set out the scope of the review including agency involvement. The Business Unit on the direction of the QiiP will:

- Set and communicate a Rapid Review date, usually 7 working days from the National panels Notification.
- Appoint a Chair and identify practitioners required to be in attendance.
- Communicate with all agencies seeking a brief submission via an Agency Involvement Form (AIF). Submissions will be expected within 3 to 4 working days from request.
- Share AIF submissions with the Chair of the Rapid Review asking them to consider key lines of enquiry for the review.
- Conduct a Rapid Review providing administrative support.

Attendance at the Rapid Review by identified agencies is mandatory. The Rapid Review will consider the incident in question with the outcome being either:

- A recommendation to proceed to a Local Child Safeguarding Practice Review where it is considered that the partnership needs to take a further and more detailed look at one or two key aspects of practice.
- A decision to not proceed to a Local Child Safeguarding Practice Review as the key aspects of learning have been identified and any further review would be duplication.

The Rapid Review should set out in a written report the discussion, analysis and final decision relating to the incident and submit it for sign off by the QiiP statutory partner's members. Due to the timely nature of reporting to the National Panel Sign off will be achieved through delegated responsibility with the QiiP Chair taking that responsibility with representatives of the three principal safeguarding partners.

Rapid Review reports should summarise the case, set out clearly issues identified and recommendations for learning including potential national recommendations. The report will also consider whether an LCSPR is needed and make recommendations to the QiiP and the National Panel accordingly.

Rapid Review Reports will be anonymised and shared with the Rapid Review Panel and QiiP members following communication from the National Child Safeguarding Practice Review Panel with a response to the report and its findings.

Rapid Review Principles

- The Rapid Review should be attended by the most relevant professionals who can confidently discuss their agencies involvement with, and knows, the child or children. As part of the request for information agencies should identify the most appropriate professional in their organisation to attend. It is recommended that front line staff are invited supported by a manger. This should be done on a case-by-case basis and not be reliant on one individual or group of individuals. The QiiP should not become the default Rapid Review Panel for all cases.
- Rapid Reviews can be independently chaired but this may not always be the best solution. Each Rapid Review should be considered individually to avoid a standardised approach to conducting a review.
- Rapid Reviews are a process to determine if an incident requires a LCSPR and they are therefore an opportunity to consider an incident to understand what can be learnt and applied to improve practice.
- Learning from Rapid Reviews must be disseminated and shared across the partnership to improve practice. This requires all QiiP representatives to share and promote the sharing of Rapid review findings as appropriate through their own agencies.

Sign Off & Governance of Rapid Review

Rapid Review Reports are submitted to the QiiP SIN Panel members for QA purposes and formal sign off. 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.

Sign off must be prompt and in keeping with the deadline set by the GSCP Business Unit who have the responsibility to ensure that Working Together Statutory Guidance timeframes are met. Data on timeliness of the process will be collated and analysed for the Executive.

Formal sign off must be sought prior to submission to the National Child Safeguarding Practice Review Panel. In addition the Rapid Review Report will be shared by the Business Unit with the Regional OFSTED Lead for the South West at or around this time.

National Panel Annual Report 2018/2019

"In the best rapid reviews, there has been thoroughness that has meant there has been no need for a further local safeguarding practice review and those areas have been able to move quickly to implement the learning across their system. These reviews feature: a concise statement of what has happened; the key questions which emerge from an appraisal of the case; a detailed and sufficient analysis which addresses those key lines of enquiry; and clearly related learning with actions to address any weaknesses".

Local Child Safeguarding Practice Reviews

Purpose

To identify, analyse and set out key areas of learning from an incident so that the partnership can address practice issues and improve safeguarding outcomes for children and families.

Process

A range of review options are open to the partnership with the methodology and rationale being set by the QiiP following receipt of a Rapid Review report that recommends proceeding to an LCSPR. The Rapid Review Report should define the area that the Rapid Review felt the partnership should focus on in its recommendation to proceed to a LCSPR and not seek a replay of the Rapid review itself.

The QiiP will set out the LCSPR arrangements on a case-by-case basis and in line with WT2018 so as not to create a single review approach but consider each incident and case on its own merits. Generally speaking, an LCSPR Review Panel will be formed with an independent Lead Reviewer, but again this may not always meet the requirement for an LCSPR.

The role of the LCSPR Panel is to work with the Lead Reviewer in the delivery of the LCSPR Methodology and the creation of an LCSPR report.

LCSPR's are required to produce and publish a report following the latest Working Together guidance.

Partners must ensure that the final report includes:

- a summary of any recommended improvements to be made by persons in the area to safeguard and promote the welfare of children.
- an analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report.

Any recommendations should be clear on what is required of the safeguarding partners and relevant agencies collectively and individually, by when, and focussed on improving outcomes for children.

Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond, so safeguarding partners must publish the report, publishing any information about the improvements that should be made following the review that they consider appropriate to publish. The name of the Chair and involved partners, relevant agencies should be included. Published reports or information must be publicly available for at least one year".

Sign Off & Governance of LCSPR's

Reports and response plans are submitted to the QiiP for QA purposes. QiiP members have a responsibility to ensure that the First Draft report and response plan is shared appropriately within their agency and to obtain their own senior management sign off prior to submission to the GSCP Executive.

It is the responsibility of the QiiP subgroup to ensure the report is ready for publication, that the response plan is being actioned, that all agencies have reviewed and signed off the report and response plan and finally that there is a publishing plan in place in which all safeguarding partners are agreed on.

All this must be in place prior to submission to the GSCP Executive with a recommendation to Publish.

Publication and imbedding of learning.

The GSCP Executive receives final LCSPR Reports, Response Plans and Publication Plans for overview and multi-agency sign off.

The GSCP Business Unit, under direction of the GSCP Executive, coordinates the submission of reports and Response Plans. Publishing reports on the GSCP Website no sooner than seven days after submission to the National Panel, Secretary of State and OFSTED.

The GSCP Business Unit will coordinate the publishing of links to the Report, its findings, practice briefings and links to relevant learning material as part of the post review learning multi agency cascade.

The QiiP Subgroup will coordinate the implementation and measuring of impact on all multi agency findings from the Rapid Review/LCSPR process. Reporting to the GSCP Executive via the GSCP Management Group on a quarterly basis.

All agencies are required to ensure that the learning from Rapid Reviews/LCSPRs are cascaded and imbedded in practice using the Section 11, and other, reporting processes to assure the GSCP Executive of compliance and changing practice.

Out of County Incidents

Where an incident occurs out of county and involves a child open to or previously known to Gloucestershire services it is the duty and responsibility of the local safeguarding partnership for the area in which an incident occurred to conduct and manage any statutory reviews; The GSCP and its Business Unit have no authority or responsibility other than to assist the responsible authority when requested to in contacting Gloucestershire Agencies. This includes but is not limited to, Child Death Reviews, Acute Life-Threatening Events, and Local Child Safeguarding Practice Reviews (including Rapid Review).

All agencies and organisations are required to respond and comply with requests from out of county safeguarding partnerships to engage fully with their local arrangements when requested to do so.

Occasionally the National Panel will recommend a Joint Review of an incident between safeguarding partnerships where a child or children are known in one or more local authority area. In these circumstances the GSCP will:

- Lead on any incident occurring in Gloucestershire and seek engagement and support from relevant out of county safeguarding partnerships, including shared costs of any review.
- Expect the safeguarding partnership where an incident occurred to lead on any review offering support via the GSCP Business Unit sharing the cost of the review.

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.

Children Placed in Gloucestershire buy Other Local Authorities (OLA's)

Children placed and living in Gloucestershire by OLA's are not considered to be 'normally resident' in Gloucestershire due to the nature of being on placement, which is not considered a long-term residency arrangement.

Therefore, any out of county incident occurring to a child placed by an OLA remains the responsibility of the county in which the incident occurred and or the OLA placing a child (where the incident occurs in another country (Wales). The GSCP and its Business Unit have no authority or responsibility for such incidents even though they are living in Gloucestershire at the time of the incident.

Links with other Statutory Review Processes

Child Death Review (CDR) and Acute Life-Threatening Event (ALTE) Reviews.

The Child Death review Partners, Gloucestershire Integrated Care Board and Gloucestershire County Council must make arrangements to review all deaths of children normally resident in the local area, and if they consider it appropriate, for any non-resident child who has died in their area. The Child Death Overview Panel (CDOP) oversees the local arrangements under the Child death review: statutory and operational guidance (England) and Working Together through the Child Death Review (CDR) team. The CDR Team are responsible for conducting and coordinating such reviews. The CDR Team comprises of the Named Nurse for Child Death employed through GHC and the Designated Doctor for Child Death employed by GHFT supported by the GSCP Business Unit Child Death Review Coordinator supported by the GSCP Business Manager or Assistant Business Manager.

In some cases, a Child Death Review or ALTE may identify a serious safeguarding concern that may meet a serious safeguarding incident threshold. In such cases the Designated Doctor for Child Death will refer the case to the GSCP Business Unit to consider under the multi-agency SIN arrangements or the Initial Child Death Review Panel will be asked to consider the SIN Threshold and make an advisory decision. This decision will be communicated by the GSCP Business Manager or Assistant Business Manager to the GSCP SIN Decision Panel for ratification.

Definitions Used under the Child Death Review Process

- **Unexpected Child Death** - An unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility, for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death. – Unexpected child deaths need to be considered regards threshold for a safeguarding review. Safeguarding

reviews do not replace the statutory CDR responsibilities but where possible joint processes will be followed to avoid duplication. It is expected that information will be shared appropriately to facilitate both statutory duties.

- **Early Neonatal & Neonatal Child Death** - **Early Neonatal Death:** when the baby dies within the first week of life (0–6 days) of any cause. **Neonatal Death:** when the baby dies within 28 days of birth of any cause or for the purpose of this process a baby who dies that has not left hospital since birth. Note: Healthcare Safety Investigation Branch, HSIB investigation is conducted separately and in parallel for Early Neonatal Death.
- **Expected Child Death** – A child with a life limiting condition and not expected to survive more than 24 hours.
- **Acute Life-Threatening Event (ALTE)** – Any sudden/unexpected collapse of an infant or child (0 up to 18 years) requiring some form of active intervention/resuscitation and subsequent intensive care/ high dependency unit admission and it remains unexplained.

Child Death / ALTE incidents may meet the threshold for a safeguarding review. Safeguarding reviews do not replace the statutory CDR responsibilities but where possible joint processes will be followed to avoid duplication. It is expected that information will be shared appropriately to facilitate both statutory duties.