(Serious) Child Safeguarding Incident Notification and Local Child Safeguarding Practice Review Procedures and Practice Guidance

October 2024 V1.6.1

Version Control

Title	**Serious Child Safeguarding Incident Notification and Child Safeguarding Review Procedure and Practice Guidance**
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Update and Approval Process			
Version	**Group/Person**	**Date**	**Comments**
DSP1	Updated by Business Unit	July 2019	Rebranded and updated to reflect new safeguarding partnership arrangements in line with Working Together to Safeguard Children 2018.
DSP1.1	Statutory Safeguarding Partners (SSP)	July 2019	Updated to reflect decision by SSP that governance of reviews sits with the Learning & Development Group. Approval of final report rests with the SSP.
DSP 1.2.1	Learning and Development Group	March 2020	Update from L & D Group to tighten up decision making following challenge to SSP on outcome of serious incident referrals.
DSP 1.3, 1.3.1 & 1.4	Learning and Development Group	February 2021 – May 2021	Updates from L&D to reflect changes in SAR procedures and formatting and Merging of Serious Child Safeguarding incident procedure into one document to simplify/reduce duplication – shared for consultation and sign off 30 April 2021.
1.5	Learning and Development Group	July 2023	Revised the referral form to ensure appropriate information is provided to support decision making. Revisions to procedure and practice guidance including details regards National Panel making referral to Ofsted. Signed off by Learning & Development Group 01/08/23
1.6 & 1.6.1		August 2024	Updated to: • Reflect new Working Together Statutory Guidance 2023 • Interface with Coronial processes added.

Issue Date	October 2024
Review Date	Two years from issue date unless legislative or practice changes identified

Contents

1. INTRODUCTION

1.1 For the purpose of this document, the term Statutory Safeguarding Partners refers to the statutory arrangements outlined in Working Together to Safeguard Children 2023. The responsibility for Safeguarding arrangements rests with the Statutory Safeguarding Partners and for Darlington they are:

- Darlington Borough Council
- Durham Constabulary
- North East and North Cumbria Integrated Care Board, Tees Valley

1.2 Child Protection in England is a complex multi-agency system with many different organisations and individuals playing a part. Sometimes a child suffers a serious injury or death as a result of child abuse or neglect. Understanding not only what happened but also why things happened as they did, can help to improve responses in the future. Understanding the impact that the actions of different organisations and agencies had on the child's life, and on the lives of his or her family, and whether or not different approaches or actions may have resulted in a different outcome, is essential to improve our collective knowledge.

1.3 This guidance has been developed to enable organisations to be clear on their responsibilities, the process for dealing with serious child safeguarding incidents and how to learn from experience and improve services. This includes the duty to conduct Local Child Safeguarding Practice Reviews, which are local reviews to examine the way agencies and individuals which have been involved with a child/ren have acted, when abuse or neglect are suspected or known. The purpose of a Local Child Safeguarding Practice Review is to identify learning that will bring about improvements, so that the likelihood of harm to children is minimised.

1.4 This guidance also outlines the process when a Learning Request is received by Darlington Safeguarding Partnership and organisations believe the incident does not meet the criteria for Notification but there is learning to be explored (to be referred to the Learning & Development Group. In addition, cases where there is good practice can also be considered.

1.5 This guidance specifies the statutory requirements and the working arrangements in respect of serious child safeguarding incidents, Local Child Safeguarding Practice Reviews and alternative learning reviews, including the interface with other reviews such as Safeguarding Adult Reviews (SAR) and Domestic Homicide Reviews (DHR).

1.6 For the purpose of this document, reference is made to the following Panels:

- **The Child Safeguarding Practice Review Panel (CSPRP);** this is the national panel appointed by the Secretary of State for Education which considers all notifications of serious incidents. The Local Authority has a duty to notify the CSPRP of any serious child safeguarding incident in their area within five days of the receipt of a notification.
- **The Rapid Review Panel;** this is the local panel which meets within fifteen days of a notification to the Child Safeguarding Practice Review Panel, to consider the

circumstances of a notifiable (serious) incident and to inform Statutory Safeguarding Partners of the Rapid Review decision.

2. DEFINITION OF A SERIOUS CHILD SAFEGUARDING INCIDENT AND 'SERIOUS HARM'

2.1 Working Together to Safeguard Children 2023 (Chapter 5) defines a serious child safeguarding incident as **circumstances where it is known or suspected that a child has been abused or neglected, which meet the following criteria**:

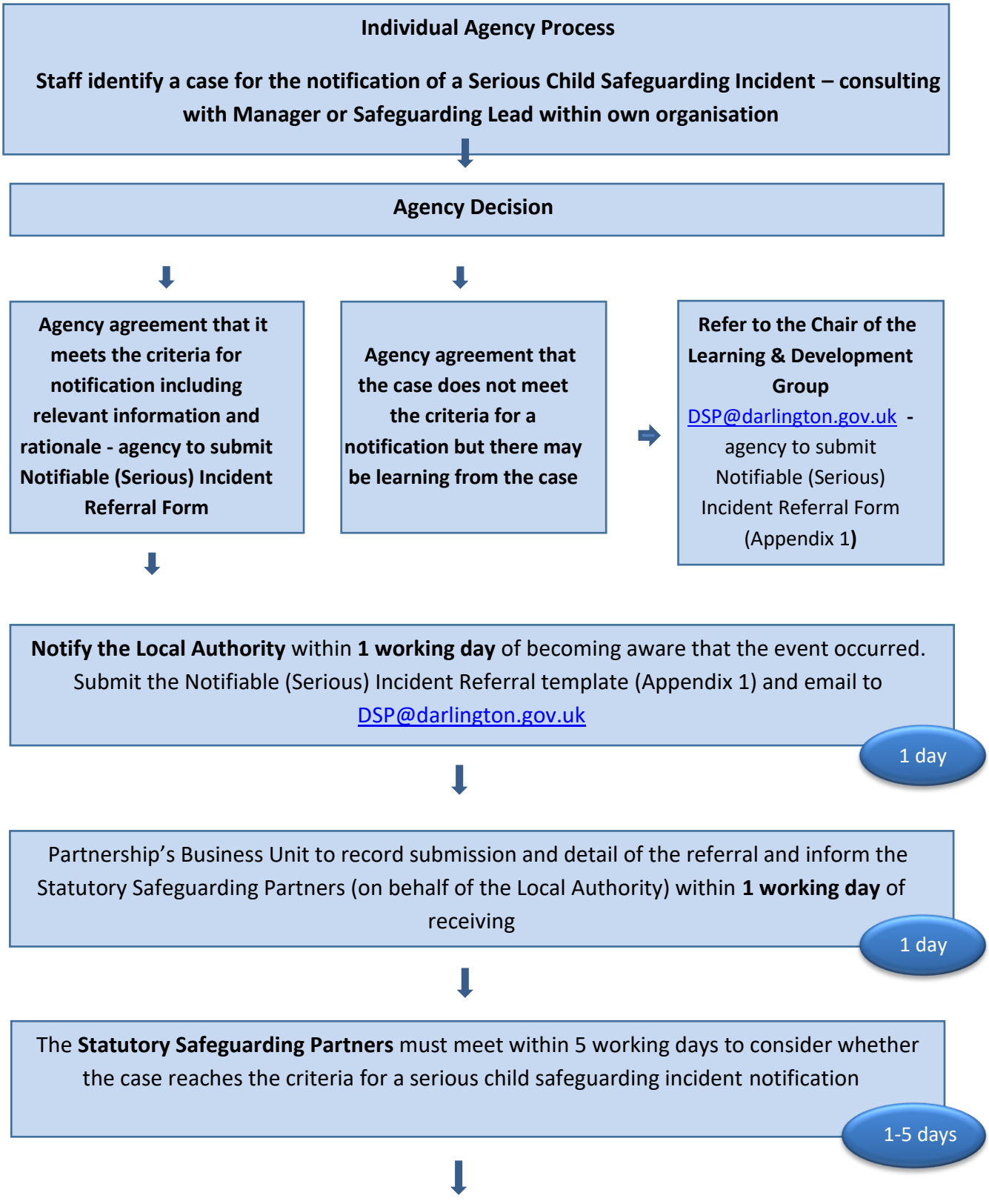
a) the child dies or is seriously harmed in the local authority's area, or
b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

2.2 'Serious harm' is defined by S 16B (9) Children Act 2004 (as amended by the Children and Social Work Act 2017), as a potentially life-threatening injury and includes serious or long-term impairment of mental health or intellectual, emotional, social, or behavioural development.

'Serious harm' is defined in Working Together to Safeguard Children 2023 as including (but not limited to), serious and/or long-term impairment of a child's mental health or intellectual, emotional, social, or behavioural development. It also covers impairment of physical health. This is not an exhaustive list and when making decisions, judgement 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.

3. PROCESS MAP OUTLINING THE PROCEDURES AND TIMESCALES

This flowchart summarises the process and timescales when considering whether a Serious Child Safeguarding Incident reaches the threshold for notification to the Child Safeguarding Practice Review Panel and the procedure which must be followed:



If the Statutory Safeguarding Partners agree the case reaches the criteria for serious child safeguarding incident notification, the Local Authority has a duty to notify the Child Safeguarding Practice Review Panel/Ofsted/DfE no later than **5 working days of** becoming aware that the event occurred

5 days

If the criteria are met, the **Statutory Safeguarding Partners** will convene a **Rapid Review Panel** within **7-10 working days** of acknowledgement from the Child Safeguarding Practice Review Panel

7-10 days

The **Statutory Safeguarding Partners** will inform the **Child Safeguarding Practice Review Panel** of their decision whether a Child Safeguarding Practice Review or national review is appropriate within **15 working days.**

15 days

The **Child Safeguarding Practice Review Panel** will consider the recommendation and review the case at the next Panel meeting to decide whether the case reaches the criteria for a national review and will advise the Statutory Safeguarding Partners in writing of the decision

If decision is made to undertake a Local Child Safeguarding Practice Review it should be completed within **6 months** of date of decision to hold

6 months

4. INITIATING A LOCAL CHILD SAFEGUARDING PRACTICE REVIEW - THE REFERRAL PROCESS

4.1 When a serious child safeguarding incident occurs, the first step for any organisation is to take appropriate action to ensure the immediate safety of the child/ren or minimise the impact of any serious harm (refer to the Darlington Safeguarding Partnership Child Protection Procedures).

4.2 Any agency or individual (including a member of the public) can refer a case for consideration of whether it meets the criteria for a LLCSPR or other review if there is learning to be explored.

4.3 If an individual within an agency considers that the criteria for notification or other review are reached, in all circumstances they should discuss this with their line manager or Safeguarding Lead in the first instance before submitting a notification and follow internal processes.

4.4 Managers and Safeguarding Leads should be aware of the criteria for the submission of a notification of a Serious Child Safeguarding Incident. A decision made as to whether a notification should be submitted, and agencies to ensure there is enough information to support the decision for a notification. You may find it helpful to discuss the concern with your agency representative on the Safeguarding Partnership, or the Safeguarding Partnership's Business Manager (DSP@darlington.gov.uk).

4.5 Where any individual or agency believes or suspects there may have been circumstances where the criteria for a notification have been met, the case **must** be referred to the Safeguarding Partnership's Business Unit. A referral is made by submitting the **Notifiable (Serious) Incident Referral Form** (Appendix 1) to the Safeguarding Partnership's Business Unit DSP@darlington.gov.uk. The referral form should be submitted within **1 working day**. You should ensure your manager is aware of the submission of the referral.

4.6 The Safeguarding Partnership's Business Manager will record the information and inform the Statutory Safeguarding Partners within **1 working day**. The Statutory Safeguarding Partners/Independent Scrutineer/Chair will meet within **5 working days** of receipt of the notification to consider the case.

4.7 If an agency agrees that the case does not meet the criteria for Notification, however highlights there may be learning to explore, the **Notifiable (Serious) Incident Referral Form** *(Appendix 1)* should be completed with relevant information and forwarded to the Safeguarding Partnership's Business Unit DSP@darlington.gov.uk.

5. RESPONSIBILITY OF THE LOCAL AUTHORITY TO INFORM STATUTORY PARTNERS AND CHILD SAFEGUARDING PRACTICE REVIEW PANEL – DECISION MAKING

5.1 The Local Authority is required to report a serious child safeguarding incident to the Statutory Safeguarding Partners within **1 working day** of becoming aware that the event has occurred (the Business Unit may do this on behalf of the Local Authority). The Statutory Safeguarding Partners will determine whether the event reaches the criteria for a notification to the Child Safeguarding Practice Review Panel, Ofsted and the Secretary of State for Education (DfE).

5.2 If the Statutory Safeguarding Partners agree that the criteria has been reached for a serious child safeguarding incident notification, the Local Authority has a statutory duty under Working Together to Safeguard Children 2023, to refer all serious child safeguarding incidents to the Child Safeguarding Practice Review Panel within **5 working days** of becoming aware that the event has occurred, using the online child safeguarding incident notification system.

5.3 Online notifications to the Child Safeguarding Practice Review Panel will also be shared with Ofsted (to inform its inspection and regulatory activity) and with DfE to enable it to carry out its functions. The Local Authority must also notify the Secretary of State for Education (DfE) and Ofsted where a child looked after has died, whether or not abuse or neglect is known or suspected.

5.4 If the Statutory Safeguarding Partners determine that a case meets the criteria for a serious child safeguarding incident, a Rapid Review Panel should be convened (see section 6 below).

5.5 If the Statutory Safeguarding Partners determine that a case does not meet the criteria for a Serious Child Safeguarding Incident notification, the SSP should consider whether there may nevertheless be the potential for single or multi-agency learning (which falls below the threshold required for a Local Child Safeguarding Practice Review), or whether practice issues have been highlighted. In these circumstances, the SSP should refer the case to the Learning and Development Group Chair, who will determine whether there should be a multi-agency practice review or a single agency review of the case. This process will be supported and monitored by the Learning and Development Group.

5.6 If the Statutory Safeguarding Partners determine that a case does not meet the criteria for a Serious Child Safeguarding Incident, and there are no single or multi-agency practice issues to be considered, no further action will be taken. Whatever the decision of the SSP, the rationale will be recorded and shared with the Learning and Development Group.

5.7 It is expected that the Local Authority will feedback to the referrer the outcome of the notification within 5 working days of the decision being made. If the referrer is dissatisfied with this outcome, the matter should be discussed with the Director of Children and Adult Services and/or the Statutory Safeguarding Partners.

5.8 **Note to Education Settings**— the Child Safeguarding Practice Review Panel will share all notifications with Ofsted and DfE therefore schools need to be mindful they may be

contacted by Ofsted who treat this information in the same way as they would if it were a complaint about the school, even if no indication the school is at fault.

6. THE RAPID REVIEW PANEL

6.1 When the Statutory Safeguarding Partners have determined that a case meets the criteria for a serious child safeguarding incident notification, a Rapid Review Panel meeting should be convened. See guidance in Working Together to Safeguard Children 2023. The Statutory Safeguarding Partners must make arrangements to:

- identify serious 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

6.2 The Rapid Review Panel should be convened **within 15 working days** of the acknowledgement of the receipt of the notification from the Child Safeguarding Practice Review Panel, however every effort will be made for a meeting to take place within **7-10 working days** to consider the information. This is to allow sufficient time to report the decision to the Child Safeguarding Practice Review Panel within the required timescales (15 working days).

6.3 Meeting the criteria does not mean that Statutory Safeguarding Partners must automatically carry out a Local Child Safeguarding Practice Review. The purpose of the Rapid Review Panel is to decide whether the serious child safeguarding incident reaches the threshold for a Local Child Safeguarding Practice Review (LCSPR), or whether it may be appropriate for a National Review

6.4 The Rapid Review Panel meeting will be chaired by a representative(s) of the Statutory Safeguarding Partners and will be attended by strategic members of the Multi-Agency Safeguarding Partnership Group and/or Learning & Development Group, supplemented by additional practitioners with the necessary knowledge or expertise pertinent to the circumstances of the case. The Rapid Review Panel may also wish to have available specialist advisers, whose role will be to advise panel members during the process.

6.5 The Rapid Review Panel meeting will have the expertise required to make the recommendation to the Statutory Safeguarding Partners. The Rapid Review Panel will be provided with information/reports from the key agencies involved, which will inform the decision making as to whether the criteria are met. This information includes the nature of agency involvement with the child(ren)/family, any safeguarding issues of which the agency was aware during the involvement, and what information the agency holds in respect of the incident. For the purposes of the Rapid Review Panel, the Statutory Safeguarding Partners will request information dating back no more than 3 years. However, if agencies believe there is relevant information outside of this timescale, this information should be shared at the meeting. It is important for the panel to have sufficient information before discussion begins. However, the Rapid Review Panel is **not investigating** the circumstances of the

incident and is **not conducting** the Local Child Safeguarding Practice Review (LCSPR), so the consideration of issues should be proportionate.

6.6 The aim of the 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 and share any learning appropriately;
- consider the potential for identifying improvements to safeguard and promote the welfare of children;
- decide what steps they should take next, including whether to undertake a Local Child Safeguarding Practice Review.

6.7 After reviewing all the information available against the criteria and guidance, the Rapid Review Panel will determine if it is considered whether the criteria for a LLCSPR have or have not been met.

6.8 If it is agreed that the LCSPR criteria are met, the Rapid Review Panel Chair will provide a recommendation to the Statutory Safeguarding Partners as to whether a national or local review is appropriate. The Rapid Review Panel Chair may also make recommendations on the review methodology and whether an independent chair and/ or author is required.

6.9 If the Rapid Review Panel considers a LCSPR should not be held, it may recommend another form of review or investigation is appropriate. This could include a single agency review or a smaller scale audit of agency involvement. This might be the case where for instance, there is a safeguarding element and lessons to be learned regarding the conduct of an agency, but where there is no or little concern regarding involvement from other agencies; or where it is considered that a broader scale review would be disproportionate to the concerns or to the learning.

6.10 Upon conclusion of the Rapid Review Panel, the outcome will be reported to the Statutory Safeguarding Partners/Independent Scrutineer who will make the final decision on the level of review. The Child Safeguarding Practice Review Panel will be informed of the decision about whether a LCSPR is appropriate, or whether it is the view of the Rapid Review Panel that the case may raise issues which are complex or of national importance, such that a national review may be appropriate. The decision of the Statutory Safeguarding Partners and Independent Scrutineer/Chair will be reported to the Child Safeguarding Review Panel within **15 working days** of the acknowledgement of the receipt of the notification.

6.11 The Child Safeguarding Practice Review Panel will notify the Statutory Safeguarding Partners of the decision as to whether:

- a national review is appropriate, setting out the rationale for the decision and the next steps;
- further information is required to support the Child Safeguarding Practice Review Panel's decision making (including whether the Statutory Safeguarding Partners/

Independent Scrutineer have taken a decision as to whether to commission a local review).

6.12 If the Child Safeguarding Practice Review Panel decides to undertake a national review, the Panel should discuss with the Statutory Safeguarding Partners the potential scope and methodology of the review and how the Panel will engage with the Statutory Safeguarding Partners and those involved in the case.

7. PURPOSE AND PRINCIPLES OF A LOCAL CHILD SAFEGUARDING PRACTICE REVIEW

7.1 The purpose of a review is to promote effective learning and improvements to practice, through identifying what the relevant agencies and individuals involved in the case might have done differently, which could have prevented harm or death.

7.2 The purpose of a LCSPR is not to hold any individual or organisation to account as other processes exist for that. These include criminal proceedings, disciplinary procedures, employment law and those of relevant service and professional regulatory bodies.

7.3 Some cases may not meet the definition of a 'serious child safeguarding case'; this may include cases where there has been good practice, poor practice or where there have been 'near-miss' events. The Statutory Safeguarding Partners may choose to undertake a Local Review in these, or other circumstances.

7.4 The level of the review will be determined by the Statutory Safeguarding Partners following a recommendation from the Rapid Review Panel.

7.5 Decisions on whether to undertake reviews should be transparent and the rationale communicated appropriately, including to families. If, following consideration, it is identified that it is not appropriate to conduct a review and the incident does not relate to the unexpected death of a child, the Statutory Safeguarding Partners will close the referral as no further action.

7.6 The Statutory Safeguarding Partners must also consider whether the case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including cases where those improvements have previously been highlighted;
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children;
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children;
- is one in which the Child Safeguarding Practice Review Panel has considered and concluded a local review may be more appropriate.

7.7 The Statutory Safeguarding Partners should also have regard to the following circumstances:

- where the Statutory Safeguarding Partners have cause for concern about the actions of a single agency;
- where there has been no agency involvement, and this gives the Statutory Safeguarding Partners a cause for concern;
- where more than one local authority, police area or Integrated Care Board is involved, including cases where families have moved round;
- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings. This includes children's homes (including secure establishments) and other settings for residential provision of children, such as custodial settings including police custody, young offender institutions and secure training centres, and all settings where the detention of a child takes place, including under the Mental Health Act 1983 or the Mental Capacity Act 2005.

8. COMMISSIONING A LOCAL CHILD SAFEGUARDING PRACTICE REVIEW

8.1 The Statutory Safeguarding Partners are responsible for commissioning and supervising reviewers for a Local Child Safeguarding Practice Review (LCSPR). In all cases it should be considered whether the reviewer has the following:

- professional knowledge, understanding and practice relevant to local child safeguarding practice reviews, including the ability to engage both with practitioners and 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 communicate findings effectively;
- whether the reviewer has any real or perceived conflict of interest.

8.2 The Statutory Safeguarding Partners will agree with the reviewer the method by which the review should be conducted. The methodology should provide a way of looking at and analysing frontline practice, as well as organisational structures and learning. The most appropriate methodology will normally be that which provides the best opportunity to learn; however, it will be determined by and proportionate to the specific circumstances and scale of the situation and should be able to reach recommendations which will improve outcomes for children. All reviews should reflect the child's perspective and family context.

8.3 The review should be conducted in accordance with NSPCC Quality Markers, which are designed to support commissioners and lead reviewers to conduct high quality reviews, by providing a consistent and robust approach to the process.

8.4 The review should be proportionate to the circumstances of the case, focus on potential learning, and establish and explain why events happened as they did.

8.5 As part of the duty to ensure that the review is of satisfactory quality, the Statutory Safeguarding Partners should seek to ensure that:

- practitioners are fully involved in reviews and invited to contribute their perspective, without fear of being blamed for actions they took in good faith;
- families, including surviving children, are invited to contribute to reviews. This is important for ensuring the child is at the centre of the process. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

8.6 The Statutory Safeguarding Partners must supervise the review to ensure that the reviewer is making satisfactory progress and the review is of satisfactory quality. The Statutory Safeguarding Partners may request information from the reviewer during the review, to enable them to assess progress and quality; such requests should be made in writing.

8.7 If the SSP have agreed to commission an independent author for the LCSPR, this should be in line with the regionally agreed process for commissioning an Independent Author, through North East Procurement Organisation (NEPO).

9. LOCAL CHILD SAFEGUARDING PRACTICE REVIEW – GOVERNANCE ARRANGEMENTS

9.1 In all LCSPR's, a Governance Group will meet to agree the scope of the review and determine the Terms of Reference. The Governance Group will be chaired by the same Chair of the Rapid Review Panel.

9.2 The Statutory Safeguarding Partners will exercise the function of having oversight of the actions via the Learning and Development Group (L&D). The Group will ensure that identified improvement actions are completed, and any barriers or slippage in achieving outcomes are responded to. All improvement actions will be recorded in an action plan, which will be regularly reviewed and monitored by the Group, which will ensure that learning outcomes are embedded in the respective organisations. The actions will be monitored within an action log and exception report, which will be monitored by the Group.

The Chair of the L&D Group will seek an explanation from relevant agencies in respect of outstanding actions and in accordance with the escalation process, will inform the relevant Head of Service in cases where actions are not completed three months beyond the specified deadline. The Chair of the Group will request confirmation of what action will be taken to rectify the matter. In cases where actions remain outstanding at six months beyond the original deadline, the Chair of the Group will inform the Chief Officer of the agency concerned and will seek information about what steps are being taken to complete the actions. An extension to the original deadline should only be agreed in exceptional circumstances and at the request of the Chief Officer. In exceptional circumstances, there may be a requirement for the Chair of the Group to involve the Statutory Safeguarding Partners in the escalation process.

9.3 Every effort should also be made before the review and whilst it is in progress, to capture points from the case about improvements needed and to take corrective action and disseminate learning.

10. REFERRAL TO THE LEARNING AND DEVELOPMENT GROUP - CASES THAT DO NOT MEET CRITERIA FOR SERIOUS CHILD SAFEGUARDING INCIDENT NOTIFICATION

10.1 Details of all serious child safeguarding incident notifications referred to the Statutory Safeguarding Partners (SSP) should be shared with the Chair of the Learning and Development Group in the interests of openness and transparency, to enable the Group to discuss and analyse the decisions made.

10.2 Details of cases which an agency agrees do not meet the criteria for Serious Incident Notification, however highlights learning to be explored, should also be shared with the Chair of the Learning and Development Group for consideration.

10.3 The SSP will have determined whether the case meets the criteria for notification to the Child Safeguarding Practice Review Panel. If the case meets the criteria, the Rapid Review Process will be followed, see section 6 above.

10.4 If the case does not meet the criteria for notification, the SSP will provide the rationale and decision.

10.5 Based on the information provided in the notification, the SSP will inform the Chair of the Learning and Development Group that there is no further action to be taken, or they recognise there is the potential for single or multi-agency learning.

10.6 The Learning and Development Group will then consider the information provided to determine:

1. Whether a multi-agency practice review should be undertaken;
2. Whether a multi-agency audit should be undertaken on similar cases;
3. Whether there is learning for a single agency and an internal review is undertaken;
4. Whether an issue is highlighted that needs to be explored further, through quality assurance processes;
5. No further action required.

10.7 The Learning and Development Group will provide details and the rationale and outcome of their decision to the SSP for approval, to progress course of action agreed.

11. INTERFACE WITH OTHER REVIEWS AND INVESTIGATIONS

11.1 There are several types of review and investigations that may interface with a Local Child Safeguarding Practice Review (LCSPR) and it is important to identify any other processes which may be running in parallel or being considered. Important principles in planning include ensuring adherence to any separate statutory requirements, ensuring appropriate expertise and knowledge, reduction of duplication, maximising effectiveness and learning, and minimising the impact on those affected by the case. It is the responsibility of the Chair of the review panel to ensure contact is made with the Chair of a parallel process.

There are a number of types of review and investigation which may interface with a LCSPR and it is important to consider any other processes which may be being considered. These may include:

- Safeguarding Adult Review (SAR)
- Domestic Homicide Review (DHR)
- Mental Health Homicide Reviews (MHHR)
- Safeguarding and serious incident investigations
- Disciplinary processes
- Judicial reviews
- Complaints
- Criminal justice processes
- YOS reviews
- Coroner inquests
- S 47 Child protection investigations
- Criminal investigations

11.2 The Statutory Safeguarding Partners must consider how the LCSPR will interface with other processes or investigations. Important principles in planning include ensuring adherence to any separate statutory requirements, ensuring appropriate expertise and knowledge, reduction of duplication, maximising effectiveness and learning and minimising the impact on those affected by the case.

11.3 Where there are possible grounds for both a LCSPR and a Safeguarding Adult Review (SAR) (or any other type of review), a decision should be made at the outset by the respective decision-making bodies as to how they will coordinate the reviews, engagement and report(s). This may result in some parts being jointly commissioned and overseen, or one body leading, with the same or different reports being taken to each commissioning body. This will necessitate a discussion between the Independent Scrutineer/Chair and the Chairs of other panels involved in a review to consider how best to proceed.

11.4 **Domestic Homicide Reviews:** Where there are possible grounds for both a Local Child Safeguarding Practice Review (LCSPR) and a Domestic Homicide Review (DHR), a decision should be made by the Chair of the DHR and the Statutory Safeguarding Partners as to how they will coordinate the reviews, engagement and reports. This may result in some parts being jointly commissioned and overseen, or one body leading, with the same or different reports being presented to each body.

Where either the victim or suspect/perpetrator were responsible for the care of a child under the age of 18, the Chair of the Community Safety Partnership should inform the Darlington Safeguarding Partnership's Business Unit of the homicide and the circumstances.

For further information see Home Office Guidance Dec 2016:
assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

11.5 **Interface between LCSPRs and Coronial Processes:** All LCSPRs need to take account of a Coroner's Inquiry and any criminal investigation, including disclosure issues, which may impact on timescales.

The Coroner must be informed of the decision to hold a LCSPR and the Chair of the review panel must ensure the necessary contacts are maintained with appropriate people.

The Business Manager will liaise with the Partnership's Legal Advisor (DBC) if any information is to be requested from the Coroner, for example to request details of death and/or inquest information. Legal advisor will liaise with the Coroner's Office on behalf of the Partnership.

The DSP Business Unit will complete the template to the Coroner informing them that a LCSPR is being commenced. ***(Appendix 3)***

Information Sharing with the Coroner: Partnerships can be instructed by the coroner to provide documents relating to an individual which are being held by the Partnership for the purposes of a LCSPR. All requests should be discussed initially with the Local Authority legal team which will liaise with the coroner regarding the sharing of information . In most cases, sharing a report that has been agreed by the agencies involved as accurate and has been approved by the Partnership should be sufficient for the purpose of an inquest. Both LCSPRs and inquests have learning as their purpose and approved reports represent the best evidence available.

It is recommended that the LCSPR is discussed with the coroner at the pre-inquest hearing, if possible, as expectations about information required and how this can be provided can be set out at an early stage. Requests for disclosure of agency IMRs or chronologies should be made directly to those agencies as they remain the data controllers. Depending on the methodology and timescales for the LCSPR there can be a number of options for sharing:

- Sharing the information disclosed to the Partnership
- Sharing a draft of the LCSPR report which has been signed off by each agency as being factually accurate, even if the format, recommendations and learning have not yet been finalised
- Sharing the completed LCSPR in full
- Sharing the learning and recommendations
- Sharing an executive summary

Being named an Interested Party: The CJA 2009 sets out at Paragraph 47(2) those who may be identified by the Coroner as an Interested Party and this includes a Local Authority and by extension a Partnership Chair, a Partnership manager or LCSPR reviewer. The Coroner has discretion to call anyone they believe has sufficient interest and such a person cannot refuse to be an interested person if the Coroner has deemed that they are an interested person. If a local authority or third party is requested to give evidence before the Coroners Court, then the person providing that evidence must be the person with the first-hand knowledge. This is a common law principle but is also enshrined in statute such as the CJA 2003. Partnership Chairs, Managers and reviewers would fit into this category if, for example, the purpose is to

provide evidence about the commissioning and completion of the LCSPR and the outcomes of implementation of LCSPR recommendations.

Timescales: Processes can run concurrently and are not co-dependent or sequential – there is no statutory guidance instructing that one should take place before the other. In some cases, there may be benefits to an inquest going ahead first, and in others there may be benefits to a LCSPR going ahead first. To assist with local decision making we have included a section on factors to consider before deciding locally (see 'Timescales') There are no rules, either in statute or guidance, on whether a LCSPR or a Coroner's inquest should take place before the other one.

12. ENGAGEMENT WITH FAMILIES

12.1 A core principle of safeguarding is to work with families in an open and honest way and this needs to be replicated in the Local Child Safeguarding Practice Review (LCSPR). Being clear about the purpose and function of the LCSPR helps manage the expectations of family members about what the LCSPR can achieve. Within this context family are usually close relatives, including those with parental responsibility.

There is an increasing body of evidence that family members, including surviving children, can make a valuable contribution to professional understanding and should be invited to contribute to the review process. Consideration will be given to the earliest point in the process that the family will be involved. In all circumstances when information is to be shared between organisations, consent issues must be discussed and obtained for family members. Where it is deemed not appropriate to seek consent, the rationale for the decisions should be clearly recorded. A decision should be made at an early stage in the LCSPR process about who is best placed to engage with the family.

13. CONSIDERATIONS FOR DISCLOSURE/INFORMATION SHARING IN A LCSPR

13.1 The Statutory Safeguarding Partners/Safeguarding Partnership are not a public authority for the purposes of the Freedom of Information Act 2000.

13.2 Section 14B of the Children Act 2004 (as amended by the Children and Social Work Act 2017), sets out expectations in relation to information sharing between agencies and the Statutory Safeguarding Partners in relation to LCSPRs, including an expectation that information must be shared to enable the Statutory Safeguarding Partners to fulfil their function.

13.3 Information must be shared in accordance with principles outlined in the Data Protection Act 2018 and General Data Protection Regulations and the Darlington Safeguarding Partnership Information Sharing Protocol.

13.4 Information Sharing with the coroner: See paragraph 11.5

14. EXPECTATIONS FOR THE FINAL REPORT

14.1 The final Local Child Safeguarding Practice Review (LCSPR) report should be completed in accordance with NSPCC quality markers (quality marker 14) and should clearly identify the analysis of the findings of the LCSPR that are key to making improvements, whilst keeping details of the family to a minimum. There is often information about the case already in the public arena, for example, media publications and anonymised family court reports and much of this information is readily available on the internet. Therefore, personal and sensitive information about family members should not be included and precise details of the case should be minimised.

14.2 The main function of the report is to make accessible the analysis to support the necessary improvement work and the report should include the following:

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

14.3 Recommendations should be clear on what is required of relevant agencies collectively and individually within specified timescales and focussed on improving outcomes for children.

14.4 Reviews are about promoting and sharing information regarding improvements, both within the area and potentially beyond, and the Statutory Safeguarding Partners should publish the report unless it is considered inappropriate to do so. The name of the reviewer should be published and published reports or information about the improvement required must be publicly available for at least one year. In circumstances where it is deemed that publication is inappropriate, consideration should be given to the publication of information about any improvements which are required.

14.5 Once completed, the final report should be shared in the first instance with the Statutory Safeguarding Partners and the Independent Scrutineer/Chair before being presented to organisations within the wider partnership.

14.6 When compiling and preparing to publish the report the Statutory Safeguarding Partners should consider how to carefully manage the impact of the publication on children, family members, practitioners and others affected by the case. The Statutory Safeguarding Partners should ensure that reports are written in such a way that publication does not harm the welfare of children and vulnerable adults involved in the case.

14.7 The Statutory Safeguarding Partners must send a copy of the full report to the Child Safeguarding Practice Review Panel and the Secretary of State, no later than **seven working days** before the date of publication. In cases where there is a decision to publish only the learning and recommendations, a copy of this must also be provided Child Safeguarding Practice Review Panel and the Secretary of State within the same timescales. The Statutory Safeguarding Partners should also provide the report (or information about improvements) to Ofsted within the same timescale.

15. MEDIA/COMMUNICATION AND PUBLICATION OF THE REPORT

15.1 The media strategy will be considered by the Rapid Review Panel/Governance Group at the beginning of the process, after the review has been commissioned and will be approved by the Statutory Safeguarding Partners. Media and communication issues will be coordinated by Darlington Borough Council Communications Team, in collaboration with the Communications Teams within the other Statutory Partner organisations and other agencies involved to ensure consistency.

15.2 In the interests of transparency, the Statutory Safeguarding Partners should consider publishing the LCSPR report within legal parameters. The Statutory Safeguarding Partners/Independent Scrutineer will make the final decision on whether the LCSPR report will be published in full or whether to publish only the learning outcomes. Advice will be sought from the Communications Teams within the Statutory Safeguarding Partner organisations, in respect of publication and media releases.

15.3 The Statutory Safeguarding Partners should also set out for the Panel and the Secretary of State, the justification for any decision not to publish either the full report or information relating to improvements. The Statutory Safeguarding Partners should have regard to any comments that the Panel or the Secretary of State may make in respect of publication.

15.4 At the point of publication, the Statutory Safeguarding Partners will release a press statement via the Communications Team outlining the reason for the review, the key findings and the required actions. The Statutory Safeguarding Partners will retain discretion over the process and timing of publication, considering such factors as ongoing criminal investigations or court proceedings.

15.5 Depending on the nature and complexity of the case, the report should be completed and published as soon as possible and no later than **six months** from the date of the decision to initiate a review. Where other proceedings may have had an impact on or delayed publication (for example, an ongoing criminal investigation, inquest or pending prosecution), the Statutory Safeguarding Partners should inform the Child Safeguarding Practice Review Panel and the Secretary of State of the reason for the delay. The Statutory Safeguarding Partners should also set out to the Child Safeguarding Practice Review Panel and the Secretary of State any decision not to publish either the full report or information relating to improvements. The Statutory Safeguarding Partners should have regard to any comments that the Child Safeguarding Practice Review Panel or the Secretary of State may make in respect of publication.

15.6 Every effort should also be made, both before the review and whilst it is in progress to:

1) capture points from the case about improvements and;
2) take corrective action and disseminate learning.

16. CONCLUSION AND DEBRIEF OF THE REVIEW

16.1 Once the review process has been completed, the Independent Reviewer will present the draft report to the Learning and Development Group, who have the governance responsibility for all reviews. The group will review the learning outcomes and suggested recommendations for improvement. The final draft report will be presented to the Statutory Safeguarding Partners and Independent Scrutineer/Chair for final sign off, before findings are shared with the wider multi-agency partnership group.

16.2 The Learning and Development Group will be responsible for determining the improvement actions, which will then be recorded into an action plan. This plan will be regularly reviewed and monitored by the Learning and Development Group, who will also ensure that learning outcomes are embedded in the respective organisations. The actions will be incorporated into an exception report which will be monitored by the Group. The Chair of the Group will seek an explanation from relevant agencies in respect of outstanding actions and in accordance with the escalation process, will inform the relevant Head of Service in cases where actions are not completed three months beyond the specified deadline. The Chair of the Group will request confirmation of what action will be taken to rectify the matter. In cases where actions remain outstanding at six months beyond the original deadline, the Chair of the Group will inform the Chief Officer of the agency concerned and will seek information about what steps are being taken to complete the action. An extension to the original deadline should only be agreed in exceptional circumstances and at the request of the Chief Officer.

17. ACTIONS IN RESPONSE TO LOCAL AND NATIONAL REVIEWS

17.1 The Statutory Safeguarding Partners should take account of the findings from their own local reviews and from all national reviews, with a view to considering how identified improvements should be implemented and embedded locally, including the way in which organisations and agencies work together to safeguard and promote the welfare of children. The Statutory Safeguarding Partners should highlight findings from reviews with relevant parties locally and should regularly audit progress on the implementation of recommended improvements. Improvement should be sustained through regular monitoring and follow up of actions by the Learning and Development Group and subsequent auditing, so that the findings from these reviews make a real impact on improving outcomes for children.

18. ANNUAL REPORT

18.1 The findings from Local Child Safeguarding Practice Reviews will be included in the Annual Report, along with relevant service improvements and actions and the reasons for any decisions not to implement actions.

Appendix 1

Notifiable (Serious) Incident Referral Form
Strictly Confidential

Local Child Safeguarding Practice Reviews are a statutory requirement for Safeguarding Partnerships as outlined in Children and Social Work Act 2017 (S17) and Working Together to Safeguard Children Statutory Guidance 2018 (Chapter 4).

This form is to be used for circumstances and/or events which either meet the criteria for notification to the Statutory Safeguarding Partners **OR** for reporting cases that do not meet the criteria for Serious Incident Notification, however highlight learning to be explored, which will be shared with the Learning & Development Group for consideration.

A notification will only by considered by the Statutory Safeguarding Partners if Section 1 & 2 are met.

For any case where you determine does not meet the criteria for notification, i.e. section 1 & 2 are not met yet but you believe there is learning to be explored such as the potential for a single or multi-agency review or audit or a practice issue has been highlighted then click option 3 below.

1.	You believe it is known or suspected that a child has been abused or neglected, which meet the following criteria:	☐
2.	• The child dies or is seriously harmed* in the local authority area • While normally resident in the local authority area, the child dies or is seriously harmed outside England	☐
3.	Does not meet criteria for Notification but there is learning to be explored (to be referred to the Learning and Development Group).	☐

*'Serious harm' is defined in Working Together to Safeguard Children 2023 as including (but not limited to), serious and/or long-term impairment of a child's mental health or intellectual, emotional, social, or behavioural development. It also covers impairment of physical health. This is not an exhaustive list and when making decisions, judgement 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 information on this form is confidential and will only be shared in accordance with the DSP Information Sharing Protocol and in the best interests of the child and family.

Darlington Safeguarding Partnership needs as much information as possible to enable Statutory Safeguarding Partners (SSP) to make a proportionate decision as to how to respond to a serious incident notification/ Local Child Safeguarding Practice Review (LLCSPR), therefore it is essential that you complete as much information on this form as possible. Pease refer to the Child Safeguarding Practice Review Significant Procedure Guidance for further guidance.

If you have any questions or wish to discuss the referral, please do not hesitate to contact the DSP Business Unit via email: DSP@darlington.gov.uk

SECTION 1: ABOUT THE PERSON COMPLETING THE FORM (REFERRING AGENCY)			
FULL NAME			
JOB TITLE			
ORGANISATION			
EMAIL		TELEPHONE NUMBER	
DATE SUBMITTED			
AUTHORISING OFFICER WITHIN AGENCY		JOB TITLE	
ORGANISATION AGREEMENT DATE:			

YOU DETERMINE THE CASE MEETS THE CRITERIA FOR NOTIFICATION (to be referred to Statutory Safeguarding Partners)	YES ☐	NO ☐	**YOU DETERMINE THE CASE <u>DOES NOT MEET</u> THE CRITERIA FOR NOTIFICATION, HOWEVER THERE IS LEARNING TO BE EXPLORED** (to be referred to the Learning & Development Group (See Section 10 of LLCSPR Protocol for further guidance)	YES ☐	NO ☐
ONCE COMPLETED PLEASE SEND SECURELY TO			**DSP@darlington.gov.uk**		

SECTION 2: ABOUT THE CHILD(REN)					
FULL NAME					
DATE OF BIRTH AGE AT TIME OF INCIDENT		GENDER	Choose an item.	ETHNICITY (if known) NATIONALITY	
ADDRESS				POSTCODE	
DATE OF SERIOUS INCIDENT		DOES INCIDENT RELATE TO DEATH OF CHILD?	YES ☐ NO ☐		
DATE OF DEATH		DOES ALLEGED INCIDENT INVOLVE THE CONDUCT OF A STAFF MEMBER?	YES ☐ NO ☐		
CAUSE OF DEATH (if applicable)					
IS A CORONER INVOLVED?		YES ☐	NO ☐	UNSURE ☐	
IF YES, RECORD DETAILS OF THE CORONER AND LOCAL AUTHORITY AREA					

SECTION 3: PARENTS/GUARDIANS			
Parent's last name:	**Parent's first name:**	**Date of birth:**	**Relationship to child:**

SECTION 4: SIBLINGS							
Sibling's last name:	**Sibling's first name:**	**Date of birth:**	**Relationship to child:**	**Gender:**	**Ethnicity:**	**Other Ethnicity:**	**Nationality: (if known)**

SECTION 5: CASE DETAILS				
What is the main cause of incident:				
Accidental Death	Accidental Injury	Drug/Solvent misuse	Natural Causes	Neglect
☐	☐	☐	☐	☐
Non-Accidental Death	Non-Accidental Injury	Road Traffic Accident	Self Harm	Sudden Infant Death Syndrome
☐	☐	☐	☐	☐
Suicide	Not Yet Known	Other	If other, please state:	
☐	☐	☐		
What are the characteristics of the case (tick all that apply):				
Alcohol abuse	Drug Abuse	Emotional Abuse	Physical Abuse	Sexual Abuse
☐	☐	☐	☐	☐
Domestic Violence	Shaken Baby Syndrome	Recent Neglect	Long Standing Neglect	Fabricated Illness
☐	☐	☐	☐	☐
More than one child abused	Parental Mental Health	Parent is in Care	Parent is Care Leaver	Child of Teenage Pregnancy
☐	☐	☐	☐	☐
Serious Illness	Not Yet Known	Other	If other, please state:	
☐	☐	☐		

SECTION 6: CHILD PROTECTION		
Was the child known to Social Care prior to the incident? YES ☐ NO ☐		
Was the child on a Child Protection Plan (CPP) at the time or prior to the incident? YES ☐ NO ☐		
Date Child Protection Plan commenced:	**Date Child Protection Plan ended:**	
Were any siblings on a Child Protection Plan at the time or prior to the incident? YES ☐ NO ☐		
Name of Sibling:	**Date CPP commenced:**	**Date CPP ended:**
Was the child on a Child In Need (CiN) Plan at the time or prior to the incident? YES ☐ NO ☐		
Date Child In Need Plan commenced:	**Date Child In Need Plan ended:**	
Were any siblings on a Child In Need Plan at the time or prior to the incident? YES ☐ NO ☐		
Name of Sibling:	**Date CiN commenced:**	**Date CiN ended:**

SECTION 7: OTHER AGENCIES INVOLVED* (please indicate all agencies that you know are involved with this child/family as this detail will be used to contact the organisations involved for further information			
Please provide agency names & details:			
FULL NAME	ORGANISATION	START DATE	END DATE

*Please add more rows if necessary

SECTION 8: DETAILS OF THE CASE/INCIDENT
This should include a clear factual outline of the serious incident with details of times, dates and where the incident took place, events leading up to the incident, people and places where possible, why the incident happened and any other details you think are important. It will also be helpful to provide a little history of the case to support and enable the Statutory Safeguarding Partners to make an informed decision on whether this meets the criteria for notification. Please also outline any action taken after the incident to safeguard the child/sibling

SECTION 9: WHY YOU BELIEVE THIS CASE MEETS THE CRITERIA FOR NOTIFICATION?
Please outline why you feel this case meets the criteria for notification. A brief overview/narrative and professional judgement is required (if not relevant, i.e. it is a learning request - insert not applicable and complete section 10 below).

SECTION 10: WHY YOU BELIEVE CASE DOES NOT MEET THE CRITERIA FOR NOTIFICTION HOWEVER THERE IS LEARNING TO BE EXPLORED?
Please outline why you feel this case meets the criteria for a Learning Request and referral into the Learning and Development Group

SECTION 11: AGENCY AUTHORISING OFFICER COMMENT & RECOMMENDATION

SECTION 12: ANY OTHER REIVEW PENDING OR COMPLETE?
e.g. Internal Agency Review, Disciplinary Processes, Professional Body Process, Criminal Investigation, MAPPA, MARAC, Domestic Homicide, Safeguarding Adult Review, LeDeR Review, Regulatory Bodies or Other (please provide details). Please provide details of any early learning or changes to practice that you may have implemented to improve or safeguard individuals going forward with your knowledge from this case. Please indicate if you are unaware of any other reviews ongoing (do not leave blank).

SECTION 13: BUSINESS UNIT USE ONLY			
DATE REFERRAL RECEIVED BY BUSINESS UNIT		DATE ACKNOWLEDGED	
IF LCSPR REFERRAL - DATE STATUTORY SAFEGUARIDNG PARTNERS NOTIFIED		IF LEARNING REQUEST - DATE REFERRED TO LEARNING & DEVELOPMENT GROUP	

STATUTORY SAFEGUARDING PARTNERS DECISION AS TO WHETHER MEETS CRITERIA FOR NOTIFICATION		
DOES MEET CRITERIA	YES ☐	NO ☐
DATE AGREED		

SUMMARY OF STATUTORY SAFEGUARDING PARTNERS DECISION

IF IT DOES NOT MEET CRITERIA FOR NOTIFICATION – DO STATUTORY SAFEGUARDING PARTNERS RECOGNISE THERE MAY BE LEARNING FROM THE CASE? *If yes, refer to chair or Learning and Development Group for consideration of next steps.* *If no, there should be no further action taken and the decision to be shared with the Chair of the Learning and Development Group for information.*		
REFERRAL TO LEARNING AND DEVELOPMENT GROUP	YES ☐	NO ☐

FEEDBACK AND OUTCOME OF REFERRAL TO REPORTING AGENCY

DATE		WHO NOTIFIED	

Appendix 2

Chronology:

Name: DOB:

Address:

Agency: Author:

Date dd/mm/yy	Time 00:00 (24hr)	Significant Event	Agency	Whose Professional/ Agency Records (Source)?	Who was involved?	Decisions/Outcome including any actions taken	Child seen/views sought: Yes/No (record the child's views)	Author Comments

Name:	This is the name of the child
DOB:	This is the child's date of birth
Address:	This is the address of the child
Agency:	This is the agency sharing the information
Author:	This is the name of the author of the chronology
Date:	This is the date the episode event is said to have taken place (not the date of recording)
Time:	This is the time the episode event is said to have taken place (not the time of recording)
Significant Event:	The significant piece of information e.g. police log of reported incidence of domestic violence: report from school that child arrives from home hungry, unkempt and tired: missed medical appointments: allegation of non-accidental injury: anonymous referral regarding child left unsupervised: Section 47 enquiry etc.
Agency:	The record from which the information was obtained, e.g. social work record, health visiting record, school nursing record, police record, probation record, etc.
Whose Professional Records:	Details of whose professional records you are referring to i.e. source of information
Whose was involved:	Who was involved in the event, e.g. the names of each individual involved in the episode including professionals, child/ren or parent/s, carer/s other adults
Decisions/Outcomes:	Comments should inform the reader of key decisions taken, any action taken and the outcome in response to the event or episode.
Child Seen/View obtained:	Yes or No. If obtained, statement re the child's views, either expressed or observations of behaviour should be noted.
Author Comments:	To provide details of author comments relating to the episode/significant event.

Please email to co-office@durham.gov.uk	
Mr Jeremy Chipperfield, HM Senior Coroner Durham and Darlington HM Coroner's Office, 4th Floor Civic Centre, North Terrace,	**Coroner Referral Form (Local Child Safeguarding Practice Review LCSPR)**

Section 1 – Darlington Safeguarding Partnership Business Unit			
Name of person submitting:		Date submitted:	
E-mail:		Referrer Contact Number:	01325 406450/451
Referring Agency Address:	Darlington Safeguarding Partnership Town Hall, Feethams, Darlington, DL1 5QT		
Secure email contact:	DSP@darlington.gov.uk	*If no secure/encrypted email function is available please ensure you clearly indicate opposite, so alternative arrangements can be agreed in line with sharing and transferring information standards.*	

Section 2 – Details of Child				
Family Name:		Forename(s):		
Date of Birth:		**Date of Death:**		
Was the child on a CiN or Child Protection Plan at the time of death?	**Yes**	**No**		

Home Address[1]:	
Place of Death[1] (Establishment/Residing)	

Section 3 – Next of Kin Details – Please record below					
Full Name		Address & Contact Detail:		Relationship:	
Full Name		Address & Contact Detail:		Relationship:	

Section 4 – Criteria for referral to HM Coroner

Referral to the Coroner's Office should only be made if;

- A child has died *and*
- The LCSPR criteria has been met *and*
- Following an endorsement by the Statutory Safeguarding Partners of the decision for a LCSPR

Section 5 – Police Involvement

Is there police involvement?	**YES**	**NO**	If, yes, please record below the details of the name(s) of officer(s) in the case and the police force (if known)

Section 6 – Reasons for Referral to the Coroner

Please record your narrative, including dates, details of the incident(s), agencies involved, and the nature of the abuse and/or injuries sustained and how this is thought to be causative or possibly causative of the death. Please refer to the Local Child Safeguarding Practice Review guidance and specifically the Coroner Annex.

[1] Addresses – please notify the Coroner if the person has died outside of County Durham but are usually resident in County Durham and if they died in County Durham but are from an establishment/usually resident outside County Durham and provide location/out of area detail.					
Section 7 – Local Child Safeguarding Practice Review (LCSPR)					
Has a LCSPR been agreed?	**Yes**	**No**	**TBC**	If, yes record the date agreed:	