

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROCEDURE ON CHILD SAFEGUARDING PRACTICE REVIEWS

1.0 INTRODUCTION

- 1.1 This procedure sets out the requirements for the Trust and staff to comply with *Working Together to Safeguard Children 2018*, and Local Safeguarding Children Partnership Procedural Guidance

The Safeguarding Partners, which are the Local Authority, Police and Clinical Commissioning Group, are responsible for instigating a Child Safeguarding Practice Review formally known as Serious Case Review (SCR).

- 1.2 The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel (the Panel) and at local level with the Safeguarding Partners. The Panel is responsible for identifying and overseeing the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance. 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.

- 1.3 Serious Child Safeguarding Cases are those where:

- Abuse or neglect of a child is known or suspected; AND
- The child has died or been seriously harmed and there is a concern on how partners have worked together to safeguard the child.
- Serious harm includes serious and/or long term impairment of a child's mental health or intellectual, emotional, social, physical or behavioral development. This definition is not exhaustive and even if a child recovers this does not mean serious harm cannot have occurred. Additionally serious harm includes a potentially life threatening injury.
- A child dies in custody or where the child was detained under the Mental Health Act.

- 1.4 The Local Authority must notify any event that meets the above criteria to the Panel 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 within five working days. The duty to notify events to the Panel rests with the local authority and others who have functions relating to children should inform the Safeguarding Partners of any incident which they think should be considered for a child safeguarding practice review.

- 1.5 When considering the criteria for a child safeguarding practice review the Safeguarding Partners must take into consideration:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified

- 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 which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate
- where the safeguarding partners have cause for concern about the actions of a single agency
- where there has been no agency involvement and this gives the safeguarding partners cause for concern
- where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around
- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings

1.6 The Safeguarding Partners will undertake a rapid review of any new case that has been referred to them for consideration. This is then shared with the national panel and has a timescale of 15 days attached to it.

1.7 When the Trust is involved in a child safeguarding practice review a Serious Incident may also be carried out which is monitored by the Clinical Commissioning Group.

1.8 When the Safeguarding Partners decision has been made to undertake a local child safeguarding practice review a Trust Individual Management Review (IMR) or alternative review, e.g. a Multi-Agency Review (MAR) methodology will be agreed if the child or parent/carer is known or has been known to the Trust. The aim of the Individual Management Review or alternate Multi-Agency Review methodology is to look openly and critically at individual and organisational practice to identify:

- Areas of good practice;
- Whether the case indicates changes could and should be made;
- How these changes will be brought about and monitored.

1.9 The findings and analysis from the review will be brought together by an Overview Author commissioned by the Safeguarding Partners child safeguarding review Panel with other agencies/organisations into an 'Overview Report'. The Trust will be expected to implement specific recommendations by the LSCB, regardless of whether the Trust is directly involved in the case

2.0 PURPOSE OF CHILD SAFEGUARDING PRACTICE REVIEWS

2.1 Establish whether there are lessons to be learned from a case about the way in which local professionals and agencies work together to safeguard children.

2.2 Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.

- 2.3 Improve inter-agency working and better safeguard and promote the welfare of children.
- 2.4 Child Safeguarding Practice Reviews are not inquiries into how a child died or who is culpable. These matters are for Coroners and Criminal Courts respectively.
- 2.5 When there is a death or serious injury of a child and abuse or neglect are suspected to be factors in that death an assessment should be undertaken of whether there are other children in the household/family who require safeguarding. Where appropriate a referral should be made to social care regarding the remaining children in the family.

3.0 PROCESS

- 3.1 Once it is known that a child/young person has died, or a case is being considered for a Child Safeguarding Practice Review the Head of Safeguarding will inform the Serious Incident Team (in order to reduce duplication of any parallel process) and the Executive Nurse.
- 3.2 The Trust Named Nurse/Practitioner Safeguarding will secure all relevant adult and child records.
- The records will be copied by the Safeguarding Team.
 - In the case of a child being taken into care the record should be forwarded on to the appropriate health professional where the child is residing.
- 3.3 The Designated Nurse for the relevant CCG should inform NHS Midlands and East and the Care Quality Commission of every case that becomes subject of a Child Safeguarding Review in their area.
- 3.4 The Trust Chief Executive will receive notification from the Child Safeguarding Partners of the Child Safeguarding Practice Review, and will be asked to nominate a Reviewing Officer to undertake the Individual Management Review (IMR). Reviewing officers will be supported by a member of the Safeguarding Team
- 3.5 Where a case involves a number of Trust services e.g. Community Health and Mental Health services, only one IMR will be required. Where it is deemed appropriate, separate IMR's maybe agreed. The Reviewing Officer will co-ordinate the collection of records and liaise with other relevant Named Safeguarding Nurses/Practitioners as required.
- 3.6 The Reviewing Officer will review all case records on the child/children in order to:
- Complete a comprehensive, factual chronology of involvement by the professionals in contact with the child/children as set out in the Child Safeguarding Practice Review's terms of reference.
 - To compile a report which looks openly and critically at the involvement of professionals/services and contains analysis of the presenting facts?

- Develop a SMART action plan.
 - Identify any omissions in the Trust or LSCB Child Protection / Safeguarding Children Policies or Child Health Procedures.
- 3.7 The review report will be completed within the set timescales as stated in the terms of reference/scoping (usually one calendar month from the request).
- 3.8 Staff involved in the case may need to be interviewed by the Reviewing Officer using the LSCB interview format. A copy of the interview summary should be given to the interviewee.
- 3.9 The Reviewing Officer should ensure that appropriate support and supervision is offered to staff and interviewees.
- 3.10 The Individual Management Report will be submitted to the Trust Mental Health Act and Safeguarding Sub-Committee and Executive Team in order that it is ratified by the Trust Chief Executive.
- 3.11 The Head of Safeguarding will liaise with the Trust Communications department as necessary.
- 3.12 Any recommendations made in the IMR will be placed on the Trust Mental Health Act and Safeguarding Sub-Committee action plan and can be implemented as soon as possible. Any subsequent recommendations made from the overview report will also be placed on the action plan and monitored monthly for compliance.
- 3.13 Once the Individual Management Report has been submitted to the Child Safeguarding Practice Review Panel a feedback process and debriefing for staff involved should take place, which may be before the completion of the final report by the panel.
- 3.14 Where the Child Safeguarding Practice Review Panel commissions an alternative case review methodology, the Trust should co-operate to influence and agree the terms of reference.
- 3.15 Trust staff will be required to participate in appropriate learning events as part of the agreed commissioned case review and will be supported by their own operational managers and the Trust Safeguarding Named Nurse/Professionals.
- 3.16 A summary of the outcomes and recommendations of the final interagency Child Safeguarding Practice Overview Report will be presented to the Trust Mental Health Act and Safeguarding Sub-Committee and reported to the Executive Team as required.
- 3.17 Child Safeguarding Practice Reviews are not part of any disciplinary enquiry or process, but information that emerges from the Individual Management Review or alternative case review methodology could indicate that actions may be required, including disciplinary action.

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- 3.18 The Full Overview Report compiled by the Child Safeguarding Practice Review Panel will be available to the public.
- 3.19 Implementation of Trust Action plans as part of the IMR or Overview report will be the responsibility of the Director of the Service/s involved in the case.
- 3.20 The implementation will be monitored via relevant service management, Community Services Safeguarding Children Groups and the Trust Mental Health Act and Safeguarding Sub-Committee.

END
