Kingston and Richmond
Safeguarding Children Partnership

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Serious Incident Notifications

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Working Together for Safeguarding Children 2018

London Child Protection Procedures

SAFEGUARDING NOTIFICATIONS

Serious Incident Notification and Case Referrals

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This guidance was signed off by the Local Learning Review Subgroup on 13.10.20. and Strategic Partners on 19.10.20.

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Introduction

1. All organisations working with children and young people have a responsibility to ensure the safety of young people, staff and the wider public within the context of the services they provide. Serious incidents are rare. However, when they do occur, they not only cause pain and suffering to those directly involved, but are likely to generate considerable media interest and threaten public confidence in the system.

2. This document sets out guidance and responsibilities for the notification of serious incidents to senior officer across every agency and organisation in Kingston or Richmond: it is not an operational procedure and should be read alongside the relevant legislation, regulations and internal and corporate procedures as they apply to specific responsibilities and settings. This document particularly rests on the guidance of Working Together 2018 and the London Child Protection Procedures 2017.

3. The term 'incident' refers to a specific event or a set of circumstances which may have taken place over time, but cause serious concerns to come to light. The term child is taken to mean all children and young people up to their 18th birthday. A serious incident may also come to light regarding a parent, regarding a child who is abroad or regarding an historical event. A serious incident may come to light regarding an organisation which volunteers or works with families or a location. It is acknowledged that there is a duty of care to the victim, which extends into adulthood and should be considered as an incident is brought to the attention of the KRSCP and investigating agencies. Please see KRSCP guidance regarding complex and historical abuse.

4. There are four possible stages to this process, which may all apply: Serious Incident Notifications, incidents which must be notified to the KRSCP, referral process for a Local Child Safeguarding Practice Review (LCSPR), whether national or local, and deaths which must be notified to CDOP (Child Death Overview Panel) review process.

5. Serious Incident Notifications are sent between agencies when there are serious concerns, such as a missing young person at risk of significant harm, they are also copied to the KRSCP.

Any situation, as indicated, below should be reported on a KRSCP's "Serious Incident Notification" form as soon as possible, and by the end of the first working day during which the incident became known. This form must be forwarded securely. This list is not exhaustive and it does not take over any operational meetings, such as Section 47 child protection enquiries for the multi-agency group. It is important that multi- agency senior partners are aware of any potential and actual serious incidents and risks, and the form has a list of partners for the originating agency to inform. The Local Learning review Subgroup may look at trends of serious incidents. Incidents such as these should be reported amongst partner agencies, or any voluntary sector agencies involved for an operational response:

Incidents and circumstances that must be notified to the KRSCP on a need to know basis for partners

Safeguarding	Missing person	Child Looked After	Death (includes notification via CDOP)	Other
There was clear evidence of a risk of **Significant Harm** to a child that was: Not recognised by organisations or individuals in contact with the child or perpetrator; **or** Not shared with others; **or** Not acted on appropriately; Serious injury / SUI, incident / near miss concerning a child or young person; A child sustains a potentially life-threatening injury or serious and permanent impairment of health (physical and / or mental) or development through abuse or neglect; A child has been subjected to serious sexual abuse, eg organised, complex abuse, grooming, trafficking; A parent has been murdered and a domestic homicide review is being initiated; A child has perpetrated a	Child at risk of significant harm is abducted / missing; Child who is looked after is missing; Pregnant woman, who has an [unborn] baby subject to a child protection plan, is missing;	Child who is looked after is missing; A child has been abused or neglected in an institutional setting (e.g. school, nursery, children or family centre, Youth Offending Institution, Secure Training Centre, children's home or Armed Services training establishment); A child was abused or neglected while being **Looked After** by the local authority (LA);	When a child dies (including death by suicide) and abuse or neglect is **known or suspected** to be a factor in the death; When a child dies in custody, either in police custody, on remand or following sentence, or a child dies who was detained under the Mental Health Act 2005; A parent has been murdered and a Domestic Homicide Review is being initiated; A child died while absent from, or having run away from home or other care setting; Any accidental occurrence causing death;	There are indications that the circumstances of the case may have national implications for systems or processes or there are significant public interest or community issues. The impact upon the local community is significant, eg honour killing, gang incident. A parent has been murdered and a domestic homicide review is being initiated; A child has perpetrated a particularly serious offence, either against another child or an adult. One or more agency or professional considers that its concerns were not taken sufficiently seriously, or acted on appropriately, by another; A serious incident of malicious damage or intrusion to premises in which a Kingston or Richmond service is being provided,

particularly serious offence, either against another child or an adult. A child has been abused or neglected in an institutional setting (e.g. school, nursery, children or family centre, Youth Offending Institution, Secure Training Centre, children's home or Armed Services training establishment); The case indicates that there may be failings in one or more aspects of the local operation of formal safeguarding children procedures, which go beyond the handling of the specific case; The child concerned was the subject of a **Child Protection Plan**, or had previously been the subject of a Child Protection Plan or their name was placed on the Child Protection Register;				resulting in actual or likely harm; Serious misconduct committed by children or young people under the supervision or in the care of Social Care, which causes harm or loss to others;

If in doubt, discuss the circumstances with the KRSCP Partnership Manager, who will take advice from the Chairs of LLR Subgroup, the Strategic Partners or another member of the Subgroup, who will decide on the appropriate action.

6. Following a serious incident notification, after liaison with the national Child Safeguarding Practice Review Panel, the KRSCP may decide to conduct a **Child Safeguarding Practice Review** for the multi-agency group. Partner agencies can recommend that a situation is considered as a case review, by the Strategic Partners. Alternatively, the National Panel may decide that there is sufficient national interest to conduct a review themselves.

Child Safeguarding Practice Review process

7. Any professional may refer a case to the KRSCP Local Learning Review Subgroup that appears to meet the criteria set out in Working Together 2018 and the London Child Protection Procedures and which he or she considers is likely to have important lessons for inter-agency working (Appendix 5 below).

    - A child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect;
    - A child has been seriously harmed as a result of being subjected to sexual abuse;
    - A parent has been murdered and a homicide review is being initiated;
    - The case highlights or may highlight improvements needed to safeguarding and promote the welfare of children and/or highlights recurrent themes in safeguarding and promotion of the welfare of children within an organisation or location;
    - The case highlights or may highlight concerns regarding two or more organisations or agencies working together;
      (Working Together to Safeguarding Children 2018)

8. The professional should notify the KRSCP Partnership Manager, and confirm the relevant details in writing. The Strategic Partners have ultimate responsibility for deciding whether to conduct a Case Review and will be advised and supported by the LLR Subgroup Chairs and members in making these decisions. The KRSCP Chair will pass the details to the Chairs of the LLR Subgroup for them to overview. KRSCP has a standing LLR Subgroup to oversee and quality assure all case reviews undertaken by the KRSCP, and to provide advice to the Strategic Partners on whether the criteria for conducting a Case Review have been met.

9. In order to decide whether the case meets the criteria for a case review, the LLR Subgroup should formally request information from key relevant partners about the child and family. The Subgroup has 15 working days to determine if a case review is required.

10. In considering whether a case meets the threshold for a case review, the KRSCP Strategic Partners will take written advice from the LLR Subgroup Chairs and members. Where the child has died, the KRSCP Strategic Partners will also use information available from the professionals involved in reviewing the child's death to assist in making this decision.

11. Instead of a multi-agency case review, the KRSCP Strategic Partners can advise an agency to conduct an Individual Management Review. A single Individual Management Review may be commissioned where there are lessons to be learned about the way in which staff worked within one agency, rather than about how agencies worked together. It may also be deemed appropriate to commission a smaller scale audit of an individual case that gives rise to concern, but does not meet the criteria for a case review. In some circumstances, it may be desirable to commission a number of agencies to conduct an Individual Management Review. These may be reviewed together in order to examine evidence of both individual and joint working arrangements.

12. Certain situations must also be reported to 'oversight organisations' CDOP, OFSTED or the Youth Justice Board for example: all of these will fall within the definition of 'serious incident'. All decisions regarding whether or not to instigate a case review following a serious incident must be promptly notified to the National Child Safeguarding Practice Review Panel.

Notification of a death to CDOP (Child Death Overview Panel)

13. Since 2008 it has been it has been a statutory duty to report all deaths of children from birth to 18 years to the Child Death Overview Panel.

14. Working Together to Safeguard Children 2018 sets out the procedures to be followed when a child dies. There are two interrelated processes for reviewing child deaths (either of which can

trigger a serious case review):

- **a Joint Area Review (JAR)** by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child
- **an overview** of all child deaths (under 18 years) by the regional Child Death Review area area(s), undertaken by a Panel.

In carrying out activities to pursue this purpose, the CDOP will meet the statutory functions set out in *The Local Safeguarding Children Boards Regulations 2006* and *WT2018* in relation to the death of any children who are normally resident in the three boroughs;

(a) Collecting and analysing information about each death with a view to identifying-

- any case giving rise to the need for a case review;
- any matters of concern affecting the safety and welfare of children in the area of the authority; and
- any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

(b) Putting in place procedures for ensuring that there is a coordinated response by the authority, their partners and other relevant persons to an unexpected death.

15. As soon as possible after the death a child death notification needs to be completed via the electronic database, eCDOP, and details should forwarded securely to the CDOP Coordinator. The Designated Doctor then confirms whether or not the death is expected or unexpected (i.e. not expected 24 hours before the death). In the event of an unexpected death, either a visit is undertaken to see the scene of the death and review events leading up to the death (ideally by the police and health representative but others may be involved) and/or a rapid response meeting is convened preferably within 72 hours of the death and involves practitioners from all agencies involved in the care of the child and is chaired by the treating team The Designated Doctor has a responsibility to alert the KRSCP Strategic Partners to any death that may meet the criteria for a CSPR. A memorandum of understanding has been developed between the CDR and the KRSCP to share information.

16. All deaths are reported to Senior Officers from all agencies and checks are undertaken to see whether or not the child was known to a service. In all cases an information gathering form is sent to all practitioners involved in the care of the child. The information from the forms is collated onto eCDOP, which is presented at the regional Child Death Overview Panel. The CDOP is accountable to the CCG and Local Authority.

17. At the panel the cause of death is classified, and modifiable factors are identified. In addition, the following actions occur

    - The Strategic Partners should be notified about any deaths where, on evaluating the available information, the CDR or CDOP considers there may be grounds to undertake further enquiries, investigations or a LCSPR and explore why this had not previously been recognized;
    - The Strategic Partners should be informed where specific new information should be passed to the coroner or other appropriate authorities;
    - Information should be to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family;
    - Monitor the support and assessment services offered to families of children who have died;
    - Monitor and advise the KRCSP on the resources and training required locally to ensure an effective inter-agency response to child deaths; this will normally be undertaken by the Designated Nurses;

- Identify any public health issues and consider, with the Director/s of Public Health, how best to address these and their implications for both the provision of services and for training;
- Learning from the Panel will be feedback to the LLR Subgroup by the Designated Nurses.

Specific situations requiring further onward notification, but not necessarily immediately to the KRSCP. All of these referrals should be included in relevant annual reports submitted to the KRSCP:

Ofsted	Youth Justice Board	Ofsted by Registered Day Care Providers	LADO	Public Health
Serious child care incident All situations requiring a Case Review, plus: Death of a Looked After Child; Death or serious harm to a child in a Children's Home; Conduct of a member of staff which has implications for the safety of children.	Death in a secure setting; Attempted suicide in a secure setting; Specified serious offences of young person/s under the supervision of the Youth Offending Team or within 20 working days after supervision has ended.	Death or serious injury to a child, A serious breach of registration requirements, Serious misconduct by staff; Other circumstances which impact on the provider's ability to offer safe care to children.	Investigation of all allegations in relation to staff or volunteers working with children; Collusion by staff with serious misconduct by children or young people. Misconduct or malpractice by staff or contractors which affects public confidence in the service. Matters of historical abuse or organised abuse.	Accidental injury or death which may have public implications;

18. Note: In addition to the above, Schools will have additional accountabilities dependent on their status and will need to report Serious Incidents to the Board of Governors, Diocesan Authority, Charity Commission and other relevant bodies, as appropriate.

Responsibility for Notification and Decision Making

19. All senior operational managers are responsible for maintaining an oversight of key areas of risk within their service and for ensuring that all staff are aware of issues and circumstances that need to be referred for their attention. All notifications should be cleared through normal line management channels. In all cases the immediate safety and well-being of the child is paramount.

20. The relevant designated person is responsible for making a judgement on the speed of notification alongside the need to gain more details. Some circumstances will need to be notified at the earliest possible point, however vague the details. There will be other situations

where it is necessary to gather more information in order to make a judgement as to the level of seriousness.

21. Additionally, a decision is required whether to;

    - Inform the agency / organisation's Press office;
    - Make an external notification;
    - Take further action.

Relationship with other public authorities

22. Where the incident occurred within the area of another local authority (at a hospital, police station or any other institution in a multi-disciplinary setting or where any other public body is otherwise involved) it is essential to establish liaison with these other key managers and, as appropriate, their communications department at the earliest possible stage. Initial enquiries should be made and contact details established.

Media

24. Before any involvement with local media, each agency must obtain communications advice from their own agency as well as from the KRSCP Strategic Partners. In all situations, the anonymity of the child must be preserved. Before any press statements are made, consideration should be given for the statement to be given by the KRSCP Chair on behalf of the Partnership rather than by individual agencies.

Appendix 1

Key Contacts Kingston and Richmond

Always notify:	Position/Agency	Contact Number
Designated Doctor for CDOP	Dr Rowan Heath	0208 934 6403/3740
Single Point of Contact SPOC CDOP Coordinator	KRSCP	07469 100 487
Can be involved:		
SPA and Multi Agency Safeguarding Hub	AfC Kingston and Richmond	0208547 5008 (Monday-Friday 8am-6pm) 0208770 5000 out of hours
KRSCP Professional Adviser	Elisabeth Major	**lscb-support@kingrichlscb.org.uk** 07833 481 774
Designated Nurse Richmond	Sian Thomas swlccg.serious-incidents@nhs.net	T: 020 3968 2370 | M: 07828 103975
Designated Nurse Kingston	Louise Doherty swlccg.serious-incidents@nhs.net	M: 07388 226574 T: 020 3968 2372
LADO (Local Authority Designated Officer)	AfC via SPA lado@achievingforchildren.org.uk	0208547 5008 (Monday-Friday 8am-6pm) 0208770 5000 out of hours
Council's Communications Team	Press Office	Richmond 020 8891 7766 Kingston
South West BCU Police	DCI Clair Kelland	0208 733 3075
Youth Justice Board		020 3334 5300 YJB.Enquiries@yjb.gsi.gov.uk
Serious Incident Notification	Ofsted	08456 40 40 40