# Croydon Serious Child Safeguarding Incident Notifications and Safeguarding Practice Reviews and Child Death Notifications

When an agency becomes aware of a serious child safeguarding incident which appears to meet the criteria above, a notification should be made to Croydon MASH and, in the event of a child death to eCDOP, see page3

## 1. Serious, Child Safeguarding Incidents

The responsibility for how the safeguarding system learns the lessons from serious child safeguarding incidents lies at a national level with the National Child Safeguarding Practice Review Panel (NCSPRP) and at local level with the **Croydon Safeguarding Children Partnership (CSCP).**

The CSCP has local arrangements in place to ensure that serious child safeguarding incidents are identified and reviewed in line with Working Together 2018.

**Serious child safeguarding cases are those in which:**

a) **the child has died or been seriously harmed, and**
b) **abuse or neglect of a child is known or suspected.**

Serious harm includes life-changing or long-term injury or an injury that is clearly life-threatening, serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development and impairment of physical health.

A serious child safeguarding case is one in which issues of local importance are raised, including effectiveness of multi-agency safeguarding practice, and in such matters the CSCP will consider if a review is appropriate. Determining the level of seriousness will sometimes need consideration and in some cases this may be difficult, for example in the cases of severe neglect, in such cases a judgement about the seriousness will need to be made.

## 2. Serious Incident Notifications

If (a) a child dies or has been seriously harmed, and (b) abuse or neglect is known or suspected – a decision on whether to submit a Serious Incident Notification to the National Child Safeguarding Panel has to be made.

> As mentioned above, some cases will be more difficult than others to decide if the case needs a Serious Incident Notification. In cases such as these, the CSCP Team will facilitate discussion between Children's Social Care, Health and Police (e.g. a meeting or email exchanges) for a **CSCP SIN Decision.** Sufficient but brief information will be shared to enable a multi-agency decision to be made.

If a SIN is to be made, the National Child Safeguarding Review Panel should be notified within 5 days of the local authority first becoming aware of the incident. **The duty to submit formal notifications of a child death or serious harm sits with the Local Authority.**

The Local Authority must *also* notify the Secretary of State if the child is a looked after child (whether or not neglect or abuse is suspected or known).

## 3. Rapid Reviews (RRs)

**A Rapid Review will take place following submission of a notification to the National Panel**. The purpose of a Rapid Review is to ascertain the facts of the case prior to the critical incident taking place and identify immediate multi-agency learning.

The Rapid Review meeting will:

- Comprise members of the CSCP Safeguarding Practice Review (SPR) Group and
- Will be chaired by the SPRG Chair
- Should not include managers involved in the case, their input will be made through information provided
- Make a decision as to whether or not a local safeguarding practice review should be carried out; this decision is shared with the National Panel.
- Submit its report to the National Panel by the date provided in their formal acknowledgement of the serious incident notification (statutory guidance is 15days).
- Determine how immediate learning will be disseminated across the agencies.

All reviews conducted will be in line with the principles set out in the CSCP Learning Improvement Framework.

## 4. Safeguarding Practice Reviews

The primary purpose of a Safeguarding Practice Review is to focus on improving learning, professional practice (collective and individual agency) and outcomes for children. The CSCP will, via the Safeguarding Practice Review Group commission a Safeguarding Practice Review and oversee the review. The Safeguarding Practice Review Group will make the decision about agree the methodology to be used for each review, this decision may be influenced by:

- Known areas of improvement needed, including where those improvements have been previously identified,
- Re-occurring themes in safeguarding and promotion of the welfare of children,
- Concerns regarding effectiveness of agencies working together and associated procedures,
- Concern about the actions of a single agency and relevant procedures
- Where there has been no agency involvement and this gives safeguarding partners cause for concern
- Where more than one local authority, police area, of CCG is involved, particularly where families have moved around
- Recommendation from the National Child Safeguarding Practice Review Panel to undertake a local review.

Any review commissioned should apply the principles of the CSCP Learning Improvement Framework; with particular regard for appreciating what works and what needs improving, and be appropriately curious and challenging. Where possible the review should be completed with a published report within 6 months of commencing.

The final report should include recommended improvements, and an analysis of any systemic or underlying reasons why actions were taken or not in respect of the matters covered by the report. Guidance on the quality of reports can be found here.

**Members of the SPRG have specific roles as follows:**

- Attend SPRG/RR meetings or ensure a proxy of similar seniority attends in their place
- Take responsibility for the timely completion of the Rapid Review Information Request/IMRs/other documents required by the coordinator. The forms may be completed by a relevant professional from their organisation, but the SPRG member is responsible for making contact with that professional as well as the quality and standard of the report.
- Liaising with the professionals from their organisation, who had contact with the child or family to ensure feedback about the purpose and outcomes of the RR or SPRG.
- Liaising with relevant professionals within their organisation, to determine whether they should attend SPRG Panels or other meetings (agreement from the Chair of these meetings will need to be sought by the coordinator)
- Take responsibility to ensure learning from Child Safeguarding Practice Reviews (or Rapid Reviews) is embedded.

## 5. Case of Concern Process

In some circumstances where the threshold to require a Significant Incident Notification is not met or the threshold for a Safeguarding Practice Review is not met after a Rapid Review there may be a need for multi-agency or single-agency review to identify learning. the SPR Group will consider how to best achieve learning from the case.

The purpose of a case of concern review is to help us identify issues within the safeguarding system and to put in place lessons learned. These are likely to be specific agency led but with learning relevant to all partners.

Any agency can request for any case to be considered for a case of concern review. The SPR Group will consider the request and agree how best to achieve learning and which agencies need to be involved. This could include an internal file review and case discussion, via an appreciative inquiry or a review of policies and procedures. Once this work is completed the outcomes will be shared with the SPR Group.

The CSCP business support team will maintain a tracker of cases presented and monitor the progress of the inquiry.

## Child Death Reviews and notification of a Child Death – see Appendix A

Child Death Review process covers children; a child is defined in the Children Act 1989 as a person under 18 years of age. A child death review must be carried out for all children regardless of the cause of death. This includes the death of any live-born baby where a death certificate has been issued.

Croydon is part of the South West London Child Death Overview Panel (SWL CDOP), along with the neighbouring boroughs of: Sutton, Merton, Wandsworth, Richmond and Kingston. All children who are residents of Croydon when they die will have their deaths reviewed at the SWL CDOP.

Prior to review at the SWL CDOP, there will have been a **Joint Agency Response (JAR)** meeting **IF** the JAR criteria is met. This must be held within 5 working days of a child's death. The Joint Agency Response meeting is chaired by the Designated Doctor for Child Death Reviews.

## 6. Joint Agency Response

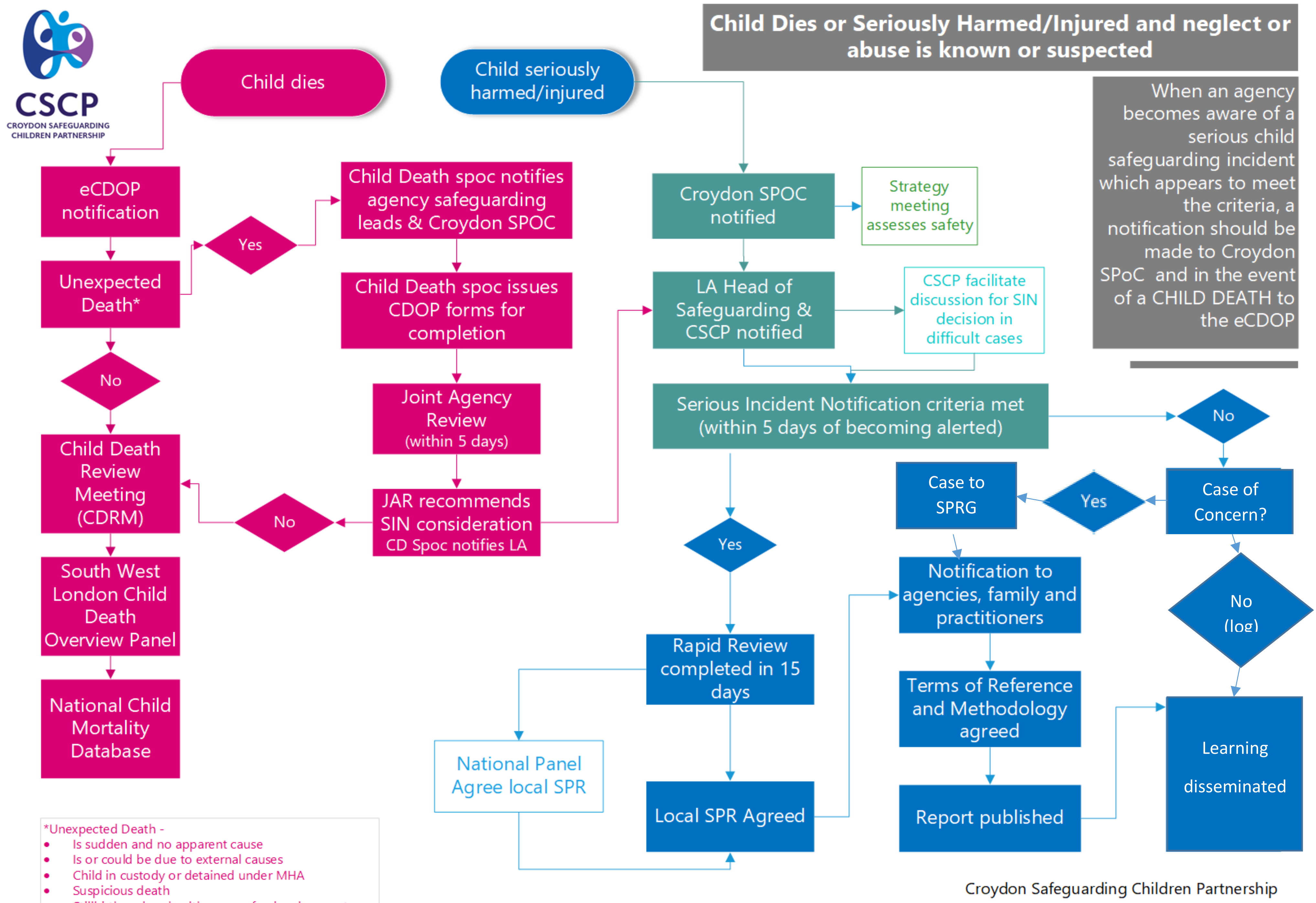
**(JAR) criteria** is set out in Working Together 2018.

A JAR is required if a child's death

- is or could be due to external causes
- is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy/childhood)
- occurs in custody, or where the child was detained under the Mental Health Act
- occurs where the initial circumstances raise any suspicions that the death may not have been natural
- occurs in the case of a stillbirth where no healthcare professional was in attendance.

If the results of any JAR investigations suggest evidence of abuse or neglect as a possible cause of death, the JAR should recommend a Serious Incident Notification (see above) to the LA Head of Safeguarding/CSCP.

All child deaths will also be subject of a Child Death Review Meeting (CDRM). The CDRM is chaired by a Consultant Paediatrician from Croydon University Hospital. This is the multi-professional meeting that takes place prior to the child death review partners review (SWL CDOP). At the meeting, all matters relating to an individual child's death are discussed by professionals involved with the case. Learning from presented cases will be published in an annual report to illustrate patterns and trends in child deaths, this data is also shared with the National Child Mortality Database.


CSCP
CROYDON SAFEGUARDING CHILDREN PARTNERSHIP
Child Dies or Seriously Harmed/Injured and neglect or abuse is known or suspected
Child dies
Child seriously harmed/injured
When an agency becomes aware of a serious child safeguarding incident which appears to meet the criteria, a notification should be made to Croydon SPoC and in the event of a CHILD DEATH to the eCDOP
eCDOP notification
Unexpected Death*
Yes
Child Death spoc notifies agency safeguarding leads & Croydon SPOC
Child Death spoc issues CDOP forms for completion
Joint Agency Review (within 5 days)
JAR recommends SIN consideration CD Spoc notifies LA
No
No
Child Death Review Meeting (CDRM)
South West London Child Death Overview Panel
National Child Mortality Database
Croydon SPOC notified
Strategy meeting assesses safety
LA Head of Safeguarding & CSCP notified
CSCP facilitate discussion for SIN decision in difficult cases
Serious Incident Notification criteria met (within 5 days of becoming alerted)
No
Case of Concern?
Yes
Case to SPRG
No (log)
Yes
Notification to agencies, family and practitioners
Terms of Reference and Methodology agreed
Report published
Learning disseminated
Rapid Review completed in 15 days
National Panel Agree local SPR
Local SPR Agreed
*Unexpected Death -
• Is sudden and no apparent cause
• Is or could be due to external causes
• Child in custody or detained under MHA
• Suspicious death
• Stillbirth and no healthcare professional present
Croydon Safeguarding Children Partnership

**APPENDIX A**

**CROYDON NOTIFICATION OF A CHILD DEATH and CHILD DEATH REVIEWS**

Any agency/professional becoming aware of:

- A child death that has occurred in Croydon; or
- A death of a child normally resident Croydon, where the death has occurred elsewhere

should make a notification to the Child Death Review Coordinator/ Single Point of Contact (SPOC)

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|---|---|
| | CDOPCroydon@croydon.gov.uk |
| | **0208 604 7392 // 07436 546 685** |
| | The completed Notification Form should be submitted to: https://www.ecdop.co.uk/croydon/live/public |

- Each agency has the responsibility to inform and support their staff affected by the death of the child.
- Following notification of the death of a child, the coordinator will establish which agencies and professionals have been involved with the child or family either prior to or at the time of death by contacting the lead professionals in each agency.
- The Agency Reporting form will then be sent by the SPOC via eCDOP to the lead professional (or professional involved) from each agency and to any professionals known to have been involved for completion as soon as possible.
- Professionals receiving a reporting form for completion should retrieve the agency's case records for the child or other family members and complete on the form any information known to them or their organisation. If information is not known, please note this on the form, rather than leaving it blank.
- The eCDOP forms guidance can be used to help complete the form.