HSSCP Review Protocol

October 2024

Hartlepool & Stockton-on-Tees
SAFEGUARDING
CHILDREN
PARTNERSHIP

Introduction

Working Together to Safeguard Children 2023 (Chapter 5) outlines how 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.

The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a local level with the safeguarding partners. Safeguarding partners must:

- identify and review serious child safeguarding cases which, in their opinion, raise issues of importance in relation to their area
- commission and oversee the review of those cases if they consider it appropriate

This protocol outlines the processes for identifying serious child safeguarding cases, making notifications to the Child Safeguarding Practice Review Panel, conducting Rapid Reviews, and the commissioning, governance and publication of local Child Safeguarding Practice Reviews (CSPR's), where required**.**

Serious Child Safeguarding cases

Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected
- the child has died or been seriously harmed

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social, or behavioural development. This is not an exhaustive list. 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.

Notifications of Serious Child Safeguarding cases must always be made if abuse or neglect is a cause of, or a contributory factor to, the serious incident or harm, or where it is suspected. However, where the family is known to Children's Social Care because of a recent incident or current concern about abuse or neglect and where there has been for example a suicide or unexplained death, professionals should also consider the incident as serious.

The local authority, on behalf of the safeguarding partners, has a duty to notify the National Child Safeguarding Practice Review Panel about all serious incidents that meet the criteria via the Child Safeguarding Online Notification System. It should do so within five working days of becoming aware it has occurred. Though the responsibility to notify rests on the local authority, it is for all three safeguarding partners to agree which incidents should be notified in their local area.

When a professional becomes aware of a case that they believe meets the criteria of a 'Serious Child Safeguarding case' as outlined above, they should complete a '**Serious Incident Notification Request Form'** and submit this to the Safeguarding Children Partnership for consideration. This should be sent to: HSSCP@hartlepool.gov.uk

Within two working days of the Serious Incident Notification Request Form being received, HSSCP will convene a teleconference in which the HSSCP Delegated Safeguarding Partners (DSPs) will consider the circumstances of the case and make a collective decision over whether or not the notification will be made to the National Child Safeguarding Practice

Review Panel. Where the decision is reached that a notification will be made, HSSCP will forward the Serious Incident Notification Request Form to the Local Authority Serious Incident Notifier. These are:

Hartlepool: leanne.stockton@hartlepool.gov.uk

Stockton-on-Tees: nicole.wilson@stockton.gov.uk

Where the decision is reached that a notification will not be made, HSSCP will reply to the referrer on behalf of the DSPs, outlining the rationale for this decision. Where there is disagreement, the safeguarding partners should follow their local 'Professional Challenge, Escalation and Dispute Resolution' procedure.

(**See Appendix 1**)

When the criteria for a serious incident notification is not met

In some cases, a 'serious child safeguarding case' may not meet the criteria for a serious incident notification but may nevertheless raise issues of importance to the local area. That might, for example, include where there has been good practice, poor practice or where there have been 'near-miss' incidents. In this instance, a '**Learning Request Form'** can be submitted to HSSCP.

The HSSCP Engine Room consider all Learning Request Forms and make a collective decision in respect of whether or not there would be learning gained from exploration of the case. Where it is felt there is learning to be gained in respect of how two or more agencies have worked together to safeguard children, the Engine Room will plan and undertake a learning review. Where it is felt that a learning review would not be required, the Engine Room will respond to the referrer, outlining the rationale for their decision.

When the criteria for a serious incident notification is not met - Rapid Review

Where the criteria for a serious incident notification is met, the notification is made by the Local Authority on behalf of the safeguarding partners via the Child Safeguarding Online Notification System, within 5 days. The Serious Incident Notifier informs HSSCP that a notification has been made. The National Panel also inform HSSCP via email that they have received a notification.

Once the Safeguarding Partnership are aware that a Serious Incident Notification has been made, they will commence the Rapid Review process. Safeguarding Partners have 15 working days from the date of notification to informing the National Panel of the Rapid Review decision.

The details of the incident / case will be shared with the key Safeguarding Partnership representatives (Engine Room members); who will become the Rapid Review panel members. One of the Engine Room representatives will take on the role of Rapid Review chair. The details will also be shared with all involved agencies and chronologies / summary of involvement will be requested.

Attendance at the Rapid Review meeting will be made up of the Rapid Review panel (Safeguarding Partnership representatives – Engine Room members) and representatives from all involved agencies. These will usually be the professionals who have completed the chronology or summary of involvement for their agency. Front line practitioners, who have had direct involvement with the child and / or family, may also be requested to attend.

During the Rapid Review, agency involvement will be discussed. Panel members will:

- gather the facts about the case, as far as they can be readily established at the time;
- discuss whether there is any immediate action needed to ensure children's safety;
- consider the potential for identifying improvements to safeguard and promote the welfare of children; and
- decide what steps they should take next, including whether or not to undertake a Local Child Safeguarding Practice Review (CSPR) or recommend that a National CSPR be considered. If the decision is taken not to proceed with a Child Safeguarding Practice Review, members will provide a summary of why it does not meet the criteria.

Following the Rapid Review, a Rapid Review report will be shared with HSSCP Executive members and a review governance meeting will be held. The Rapid Review chair will be invited to attend to share the findings of the review and report with Executive members. The Executive members will consider the recommendation(s) of the Rapid Review panel and report and make the final decision over whether or not the criteria for a local Child Safeguarding Practice Review has been met and will be commissioned. It is for safeguarding partners to determine whether a review is appropriate, given that the purpose of a review is to identify improvements to practice. Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. The criteria safeguarding partners must take into account include whether the case:

- 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 the national panel has considered and has concluded a local review may be more appropriate

Safeguarding partners should also have regard to circumstances where:

- they have cause for concern about the actions of a single agency
- there has been no agency involvement, and this gives them cause for concern
- more than one local authority, police area or ICB is involved, including in cases where a family has moved around
- the case may raise issues related to safeguarding or promoting the welfare of children in institutional settings

These form part of the questions asked as part of the Rapid Review meeting and are included within the Rapid Review Report to aid the decision-making of the Executive members.

The partnership chair will add the final decision to the Rapid Review report and this will be submitted to the National Panel, informing them of the outcome. This is submitted to the National Panel within 15 working days of the serious incident notification. The National Panel will aim to respond to the submission, to indicate whether or not they agree with the outcome, within 15 working days. (**See appendix 2**).

The Rapid Review recommendations and actions feed into and are progressed by the HSSCP Engine Room.

Local Child Safeguarding Practice Review (LCSPR)

Following the governance meeting, if the decision has been made to progress the case to a LCSPR, a TOR planning meeting will be held. This will include the HSSCP Business Manager, Rapid Review Chair and Partnership Chair. Additional partnership representatives may also be included as necessary. The scope of the review will be drafted as a Terms of Reference and circulated to wider Executive members for comment and approval. A reviewer will then be commissioned. When appointing a reviewer the HSSCP Executive should consider whether the reviewer has:

- professional knowledge, understanding and practice relevant to local child safeguarding practice reviews, including the ability to engage with practitioners, 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
- the ability to understand practice from the viewpoint of the individuals, organisations or agencies involved at the time rather than using hindsight
- the ability to communicate findings effectively
- any real or perceived conflict of interest

The above is included within the commissioning 'Call-Off Alert' for commissioning external reviewers.

Once HSSCP Executive members have agreed upon the reviewer, the national panel, Ofsted and DfE should be informed of the name of the reviewer undertaking the review.

HSSCP Executive members form the governance for the review and dedicated stand-alone governance meetings are included in the TOR for the review as 'checkpoints'. As part of their duty to ensure the review is of satisfactory quality, the safeguarding partners should ensure that:

- practitioners are fully involved and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
- families, including surviving children (in order that the child is at the centre of the process) are invited to contribute
- families understand how they are going to be involved and have their expectations appropriately and sensitively managed

As part of their governance role, the Executive members must also ensure the final report includes:

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

Any recommendations should make clear what is required of relevant agencies and others both collectively and individually, and by when, and focussed on improving outcomes for children.

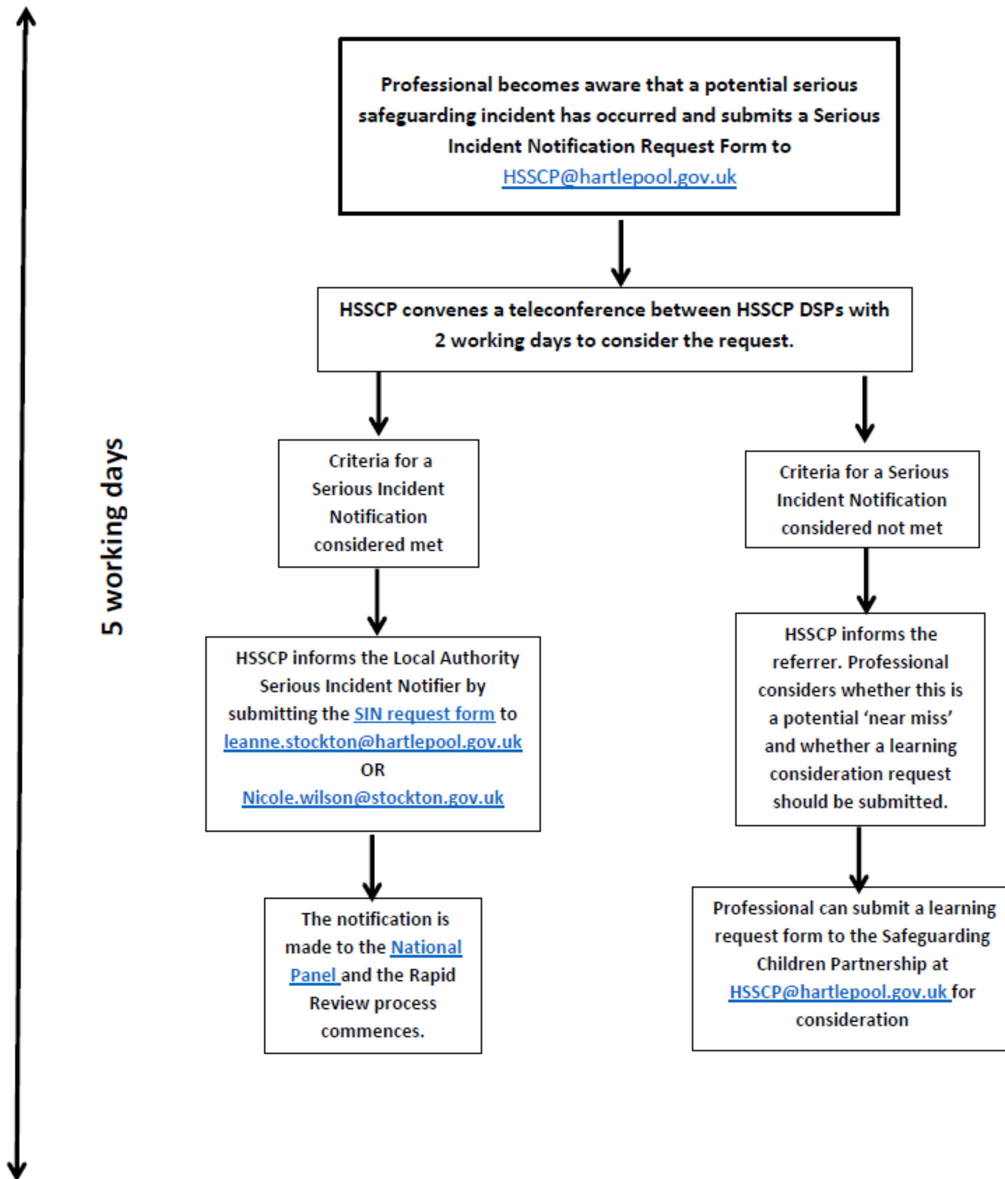
Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond, so HSSCP must publish the report, unless the Executive members consider it inappropriate to do so. As part of the final governance meeting, Executive members will be asked to consider whether they envisage any issues in publication. In such a circumstance, they must publish any information about the improvements that should be made following the review they consider appropriate to publish. They should consider carefully how best to manage the impact of the publication on children, family members, practitioners and others closely affected by the case and ensure that reports are written in such a way so that what is published avoids harming the welfare of any children or vulnerable adults involved in the case. The name of the reviewers should be included. Reports should be published 6 months following the decision to initiate the review and reports or information must be publicly available for at least one year.

A copy of the full report is shared with the national panel and to the Secretary of State no later than seven working days *before* the date of publication. Where it has been decided only to publish information relating to the improvements to be made following the review, a copy of that information will also be shared with the panel and the Secretary of State within the same timescale. The report, or information about improvements, is sent to Ofsted within the same timescale. (**See Appendix 3**)

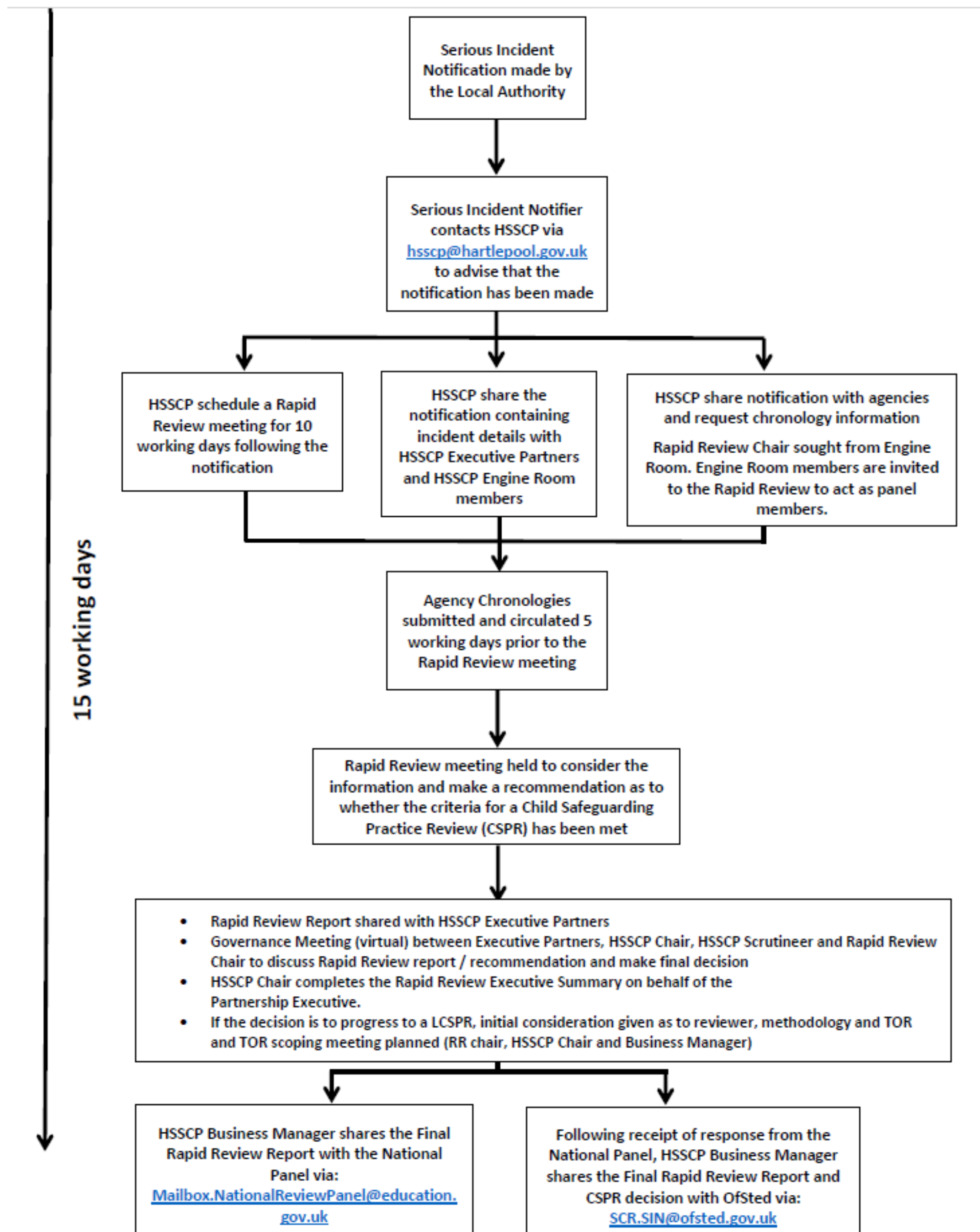
Where other proceedings may have an impact on or delay publication, (for example, an ongoing criminal investigation, inquest or future prosecution), the safeguarding partners should inform the panel and the Secretary of State of the reasons for the delay. Safeguarding partners should also set out for the panel and the Secretary of State the justification for any decision not to publish either the full report or information relating to improvements. Safeguarding partners should have regard to any comments that the panel or the Secretary of State may make in respect of publication. (**See Appendix 4**)

HSSCP will 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 locally, including the way in which organisations and agencies work together to safeguard and promote the welfare of children. The HSSCP Engine Room will 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 so that the findings from these reviews make a real impact on improving outcomes for children.

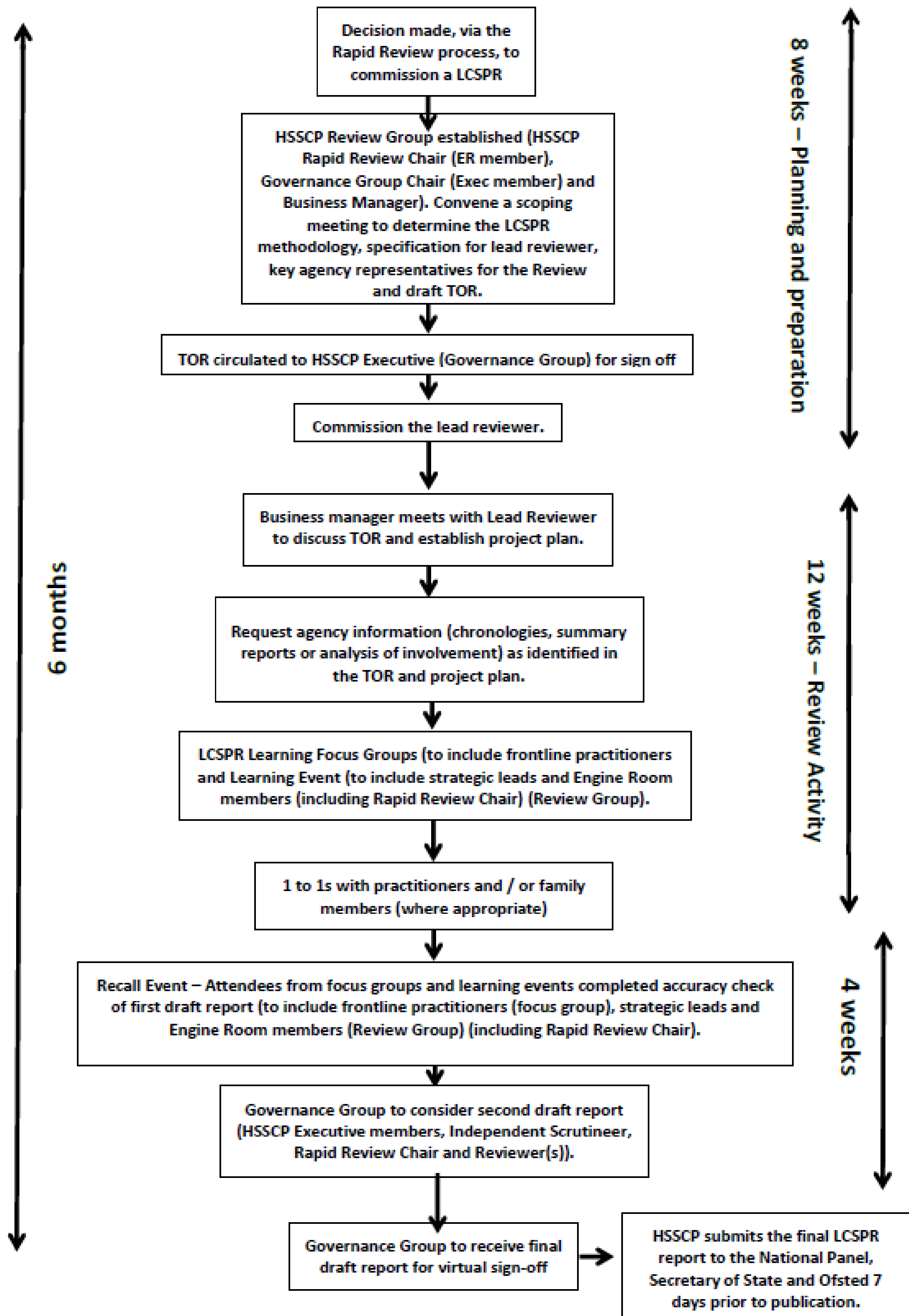
APPENDIX 1: Serious Incident Notification Process



APPENDIX 2: Rapid Review Process



APPENDIX 3: LCSPR Process



APPENDIX 4: Final Governance Meeting Agenda

HSSCP Governance Meeting (Add Child's Initials)

Add date and time
Microsoft Teams

Agenda Items:

Item no.	Item Outline:	Time	Attachment	Presented by:
1	**Attendance & Apologies** ∞			
2	**HSSCP LCSPR (Add Child's Initials) Report**			
	a) HSSCP LCSPR Final Draft Report			Lead Reviewer to attend
	b) For info: i) HSSCP LCSPR TOR v4 ii) Rapid Review Report (Both previously seen)			
3	**Publication**			
	a) Areas for consideration: i) Any court proceeding implications ii) Any criminal proceeding implications iii) Any media interest implications			
4	**AOB**			
	a) Partner Updates (If applicable) ∞			All

= Document attached to email ∞ = verbal = Report to follow