

**Trafford Children, Families and Wellbeing Directorate**

**Serious Incidents, LIC Referrals and Internal Management Reviews.**

**February 2018**

1. **Policy & Procedure**

Trafford follows the Greater Manchester approved procedure on Serious Incidents as laid out in the North West Learning Improvement Framework and contained in our Safeguarding Procedures: <http://greatermanchesterscb.proceduresonline.com/chapters/p_nw_learn_imp_framework.html>

1. **Internal Notification**

The Service identifies cases which could be viewed as Serious Incidents as follows:

* the social worker or their manager becomes aware that there has been a serious incident and reports this to their Strategic Lead for consideration
* an internal audit process may have identified a case
* the IRO service may identify a case through the Child Protection Conference Process or through the IRO LAC process
* a referral to MARAT (especially from Police or Health) or a Strategy meeting may make an identification
* it is brought to the attention of the Strategic Lead by a member of staff, partner agency or member of the community

1. **Serious Incident Notification**

Internal process for identifying and processing Serious Incidents:

* Cases are brought to the attention of the relevant Strategic Lead as described above.
* The Strategic Lead reviews the available information, takes a view on what action is required and forwards all appropriate information to the Director (Safeguarding and Professional Development) and the other relevant Strategic Leads.
* The Director will make the final decision on whether the case fits the criteria for notification to Ofsted as a SIN, should be referred to the TSCB LIC Committee for their view on suitability for a SCR or multi-agency learning review or we should hold an Internal Management Review of the case.
* The DCS should be informed of any SIN by the Director.

*Local Authorities should notify OFSTED of serious incidents (Local Authority Circular LAC(2007)25) involving children which:*

* *are serious enough that they may lead to a Serious Case Review, including where a child has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect; or*
* *involve a child death and will automatically lead to a Serious Case Review (when a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the child’s death); or*
* *should be brought to the attention of Ofsted and the Government because of concern about professional practice or implications for Government policy; or*
* *raise issues about a council’s professional practice that may need to be considered further in the context of performance assessment; or*
* *have attracted or are likely to attract media attention.*

*Local authorities are also obliged to inform Ofsted of the death of a child looked after and of every case that becomes the subject of a serious case review. Ofsted passes the information from these serious incident notifications to the Department for Education.*

If it is agreed that an incident reaches the threshold for notification to OFSTED as a SIN, the TSCB LIC Committee will also be informed that this threshold has been reached.

1. **LIC Notifications**

When consideration is given to referring a case to LIC (TSCB Learning & Improvement Committee) for consideration of a SCR the following criteria is used (Working Together 2015):

1. *Abuse or Neglect of a child is known or suspected; AND*
2. *Either:* 
   1. *The child has died; OR*
   2. *The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.*

*Thus cases meeting either of these criteria must always trigger a Serious Case Review:*

1. *Abuse or Neglect of a child is known or suspected AND the child has died (including by suicide); OR*
2. *Abuse or Neglect of a child is known or suspected AND the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. In this situation, unless it is clear that there are no concerns about inter-agency working, a Serious Case Review must be commissioned.*

Additionally, even if these criteria are not met a Serious Case Review should always be carried out when:

* *A child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children's home or where the child was detained under the Mental Health Act 1983 or where a child aged 16 or 17 was the subject of a deprivation of liberty order under the Mental Capacity Act 2005.*

The purpose of the Review is to establish whether there are lessons to be learned from the case, identify what those lessons are and how they will be acted upon and improve inter-agency working as a result.

Cases should also be referred to the TSCB Learning and Improvement Committee where the threshold for a SCR is not considered to be met but where there may be valuable lessons about how Trafford agencies work together to safeguard children. Such cases should be discussed in the first instance with the relevant Strategic Lead.

Link for referral to TSCB LIC: <http://www.tscb.co.uk/docs/case-review-notification-form.doc>

1. **Cases that do not reach threshold for LIC (Internal Agency Review)**

The Greater Manchester procedure states that if a case does not reach the threshold for a LIC led review then it should be considered for an Individual Agency Review:

* *Where a case is considered for a serious case review or multi-agency concise review but does not meet the criteria, as practice requiring further analysis and learning is limited to a single agency, the SCR Panel (or relevant Quality Assurance Group) may recommend an Individual Agency Review. The methodology used to undertake a review and how the lessons will be disseminated will be decided locally by each LSCB*

The decision to hold an Internal Agency Review of a case will be done through the relevant Strategic Lead and the final decision will rest with the Director (Safeguarding & Professional Leadership). Any learning from such a review should be reported to the Monthly DCS Safeguarding Meeting.

**Chris Reilly 20.02.2018**