Document 1 - Deciding Whether to Notify

Who should make a notification?

The duty to notify serious incidents to the National Panel sits with local authorities.

However, good practice suggests that the local authority should, wherever possible, consult with other Safeguarding Partners when deciding whether to notify.

When should a notification be made?

A notification should be made if a ***child dies or is seriously harmed*** in the local authority area (or outside of England while they are normally resident in the local authority area) **AND** ***abuse or neglect is known or suspected***.

(Local authorities have a separate duty to notify the Secretary of State and Ofsted where a looked after child has died, whether abuse or neglect is known or suspected.)

Advice from the National Panel

What constitutes abuse and neglect?

The National Panel interpret this as meaning there was sufficient reason to suspect that abuse or neglect was present and, at least in some way, caused or contributed to the death or serious harm.

If the event is in itself abusive, for example the child was murdered by a parent or carer, the Panel believes the criteria would have been met, regardless of whether or not there was pre-existing evidence of abuse or neglect.

Alternatively, the criteria would be met, if there is sufficient concern to trigger a strategy discussion, section 47 investigation, or care proceedings, or evidence to initiate a criminal investigation for possible abuse or neglect. The local authority does not need to wait until abuse or neglect is proven to make a notification and for a Rapid Review to commence.

Looked After Children

Local authorities are required to notify the Secretary of State and Ofsted when any looked after child died. While all such cases, including deaths by suicide, accidents and medical causes must be notified, unless abuse or neglect was known or suspected to have contributed directly to the death, these cases do not need a Rapid Review.

Where a looked after child has experienced recent abuse or neglect, or criminal or sexual exploitation, that is linked to the death or serious harm, then a Rapid Review should be undertaken.

Neglect

Working Together 2018 defines neglect as: *'The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.'*

In cases where incidents of neglectful care have resulted in death or serious harm, without any apparent evidence of this being a pattern of persistent failure to meet the child's needs, consideration should be given as to whether the actions of the parent or carer were neglectful in and of themselves (in which case, neglect is suspected) and the outcome for the child has resulted in death or serious harm.

In other situations of neglect (or, indeed, other forms of maltreatment), there may be no single incident, but it is the cumulative effect of the neglect that is considered to meet the criteria of serious harm to the child. In such situations, the case should be notified as soon as the local authority or Safeguarding Partners become aware of the serious harm.

Sudden Unexpected Death in Infancy (SUDI)

Most SUDI cases are appropriately reviewed through the child death review process and do not require a Rapid Review or LCSPR. Where abuse or neglect is considered to have directly contributed to the death (for example in cases of severe and persistent neglect with evidence of dangerous sleeping environments) then a Rapid Review should be undertaken.

Where an individual SUDI case reflects issues already explored in that national review – *Out of Routine* – the National Panel advises Safeguarding Partners carefully consider what additional local learning is likely to be achieved through an LCSPR.

Suicides

Most suicides in young people are appropriately reviewed through the child death review process and do not require a Rapid Review or LCSPR. Where abuse or neglect is considered to have directly contributed to the death, then a Rapid Review should be undertaken.

Extrafamilial Harm

When deciding whether to notify such cases of extrafamilial harm, and subsequently whether to undertake a Rapid Review or LCSPR, the National Panel suggests consideration is given to the following questions:

1. Is the death/serious harm caused by or directly related to actions or omissions of an adult with caring responsibilities for the child, or in a position of power or control in relation to the child?

2. Do the actions or omissions of any adult in relation to this child meet the definitions of either child sexual exploitation (CSE) or criminal exploitation?

3. Is the death/serious harm caused by or directly related to actions or omissions of an adult without any caring responsibilities for the child or in a position of power/control/trust in relation to the child, and without evidence of exploitation?

4. Is the death/serious harm caused by or directly related to actions or omissions of another child or young person without any evidence of any coercion or exploitation by an adult?

If the harm has been caused by an adult without caring responsibilities or in a position of power/control/trust, then that would typically constitute extra-familial violence rather than abuse or neglect. If the harm has been caused by another child, without any evidence of adult involvement or coercion, that would typically constitute child-on-child violence rather than being considered abuse or neglect.

In cases of extra-familial or child-on-child violence without any evidence or suspicion of exploitation or of coercion by adults, decisions on whether to notify and carry out a Rapid Review should be based on whether there are safeguarding concerns associated with the case. In determining this, safeguarding partners should consider the ability of the parents or carers to provide a safe and nurturing environment for the child, the role of different agencies in supporting the child and family, whether the victim was known to children's services as well as the possible impact of multi-agency action or inaction. For example, risk assessments, school exclusion, failures to address known trauma. In any such cases, consideration should be given to the potential for meaningful learning around safeguarding in deciding whether to undertake an LCSPR.

One further consideration in cases of extra-familial harm is whether the death/serious harm was caused by or directly related to actions or omissions of an adult with caring responsibilities for the child, or in a position of power/control/trust in relation to the child within the context of a particular institution. In such cases, the safeguarding partners may wish to consider whether this constitutes institutional abuse or neglect.

However, where the harm suffered was related to the quality of care provided in the institution, rather than being caused by or directly related to specific actions or omissions of an adult with caring responsibilities for the child, or in a position of power/control/trust in relation to the child within the institution, this may be a quality-of-care issue rather than institutional abuse or neglect. Key considerations here may be whether the harm was specifically targeted towards one or more children in the institution rather than simply being poor standards/quality of care that happened to affect that child, and whether the child/children in question were particularly vulnerable, for example those with learning disabilities or those known to be at risk of exploitation.

The National Panel published their national thematic review of child criminal exploitation, *It was hard to escape*, in 2020. Safeguarding Partners should consider the learning from that review in their consideration of any cases of possible criminal exploitation.