Intro

A new Significant Child Protection Incident Review aims to help staff prevent or minimise recurrence and future harm of children they suspect of being at risk.

In any event where a member of staff suspects, or has concerns about a possible suspicious death or near death of a child, they can request a review via Child Protection Unit staff. The Review Procedure, copied below, explains the purpose of the procedure and how it will work.

Child Protection Significant Incident Review Procedure NHSGG

Purpose of a Significant Child Protection Incident Review NHSGG
The purpose of a Significant Child Protection Incident Review NHSGG is to:

- Establish whether there are lessons to be learned
- Establish what is to be learned
- Recommend actions to bring about change as a result via improvement plans

The arm is to prevent or minimise recurrence, thus reducing future risk of harm.

Reviews should identify strengths and weaknesses regarding performance issues, failures in management systems, and satisfy necessary legal and regulatory requirements.

When a child has died, a significant incident review is not an enquiry into this, or who is culpable; these are matters for a Fatal Accident Enquiry and the courts to determine as appropriate.

It is important to note that not all incidents will require a review.

The findings of a significant child protection incident review NHSGG may inform an inter agency review that could be requested by the Child Protection Committee.

Circumstances in which a review should take place
Circumstances in which a review should take place are as follows:

- Any death of a child where there is suspicion or concern about possible child protection issues
- Any near miss death of a child where there is suspicion or concern about child protection issues
- Where there is suspicion of failure to adhere to child protection procedures: an example is failure in communication or information sharing within NHSGG or outwith NHSGG to other agencies where this was appropriate and necessary.

Who can request a review?
In any of the above circumstances any member of staff can request a review via Child Protection Unit staff (Head of Child Protection Development, Child Protection Advisors).

Child Protection Unit Advisors will offer advice and support.

Any NHSGG staff member should be aware that where they have concerns as a minimum they must report it to their line manager who may then request a review.

A review can also be requested by:

- Other agencies
- Child Protection Committees

Staff with the authority to commission such a review and timescales
The Chair of Child Protection Forum has the authority to commission a review.

A decision on whether to conduct a review should be made by the Chair of the Child Protection Forum within 4 weeks of receipt of the request. The Chair of the Child Protection Forum should advise the Head of Service of this decision within 2 days.

The Chair of the Child Protection Forum should then determine the membership of a review group within 2 weeks.

The review group should meet within 4 weeks of this decision to plan the scope of the review.

It is the responsibility of the Head of Child Protection Development to oversee and track progress of these reviews.

Core Members of the Review Group

- Medical Director or equivalent
- Director of Women and Children's Services or nominated deputy
- Lead Clinician Child Protection / Child Protection Advisor
- Additional specialist input as required e.g.
    - Central Legal Office
    - Human Resources
    - External Clinical Advice

The Chair of the Child Protection Forum will decide the chair of the review group and can appoint an independent chair where required.

Review Group role and remit

The role of the review group is to plan the scope of the review, decide on staff, methodology, and timescales.

Review group will determine the process. The reporting line for the group will normally be to the Chair of the Child Protection Forum.

At the start of any review, the group terms of reference will be clearly and explicitly agreed. This will include:

- Purpose and desired outcomes
- Boundaries
- Communication arrangements in respect of the process and the outcome.
- Individual roles and responsibilities
- Interaction with Clinical Governance structures, Interagency Child Protection Committee, Child Protection Forum

Key components of a review

A review should:

- Collect evidence about what happened
- Assemble and consider the evidence
- Compare the findings with relevant standards, protocols or guidelines
- Suggest possible causes if appropriate
- Make recommendations for action to minimise risks
- Draft up an improvement plan with priorities, actions, responsibilities, timescales and strategies for measuring the effectiveness of the actions
- Communicate the findings and recommendations for action with relevant staff
- Recommend implementation the improvement strategy

Methodology may involve techniques used in Root Cause Analysis, for example:

- Face to face staff interviews
- Telephone interviews
- Case record analysis
- Expert consultation

Staff involved in significant case reviews should have undergone training in Root Cause Analysis.

Reporting format of significant child protection incident review NHSGG to Review Group
The following is drawn from *"Six Steps to Root Cause Analysis", Maria Dineen, 2004*

Executive Summary
Introduction: provide an introduction to the purpose of the report.

Contributors: Identify the members of the investigation team; Teams/persons involved in the incident; witnesses to the event; other persons who contributed information to assist the investigation. Assign all persons directly involved in the event a coded reference e.g. Baby J. which will then be used throughout the main body of the report.

Outline a summary of the incident and its consequences: Include a brief synopsis of the antecedents, the incident itself and its consequences in terms of the degree of harm/damage caused and the remedies required to repair the harm/damage.

Stage in care process that event occurred: Identify the stage in the care process that the event occurred) e.g. pre-treatment, intra –treatment, post –treatment, at discharge).

List the problems or issues that were considered to be of greatest significance (i.e. all those directly impacting on the outcome or course of this event).

Identify those influencing factors that have been identified as root causes or fundamental issues.

List the improvement strategies or recommendations made for addressing the issues highlighted above. Indicate responsible person for ensuring implementation of the action and timescale.

Other additional learning opportunities: draw here on the positive contributory factors that might be used to promulgate safe practice across the organisation.

Main body of report
Outline of the investigation process: provide an outline of the investigation process, why various tools/methodologies were used i.e. their particular merits for this particular case. State why a significant incident review was organised.

Full chronology of events: present the full detail of the chain of events as a traditional chronology, or insert a diagrammatic timeline.

List all identified problems or issues of concern identified during this investigation.

Reporting format of significant child protection incident review NHSGG to Child Protection Committee significant case review
Reports should include the following information:

- Introduction
- Family composition and involvement with agency
- Level of agency involvement (to include all the services provided by the agency)
- Chronology of contact (to include dates and brief description of contact)
- History of agency's involvement (to include focus of agenc's involvement, intra agency communication etc)
- Key single agency issues
- Key inter agency issues
- Conclusion/action points

Relationship of the Review to Disciplinary Procedure

Any review into a serious child protection incident cannot preclude use of the disciplinary process where there has been a serious breach of professional practice. However in the event that a disciplinary procedure is invoked, the reasoning for its use will be discussed with the Review Team. The spirit of the review will be characterised by a no blame culture.

'No blame culture' in this context means that the purpose of the Review is to identify Root Cause or system failures. Staff will not be 'blamed' for system failures or their consequences; however, they retain individual responsibility for their own actions or inactions in accordance with the professional codes that apply to them and their professional practice.

If it is required to invoke disciplinary procedures this must be referred back to the appropriate manager. Although the review is not in itself a disciplinary process it would be always be open to staff giving evidence to be accompanied by a representative of their choice.

Efforts will be made to limit circulation of information on a "need to know " basis and to anonymise it where possible and appropriate. Whilst efforts will be made to respect confidentiality, there will be circumstances where information will have to be shared.

Parameters:

- In the unlikely event that the review uncovers any criminal, potentially criminal or reckless behaviour, then the review must stop and the appropriate criminal investigation process should be used.
- If the review uncovers professional misconduct, including malicious or reckless behaviour, which may be construed as gross misconduct or a serious breach of the individual's professional code of conduct, then the Disciplinary process will be invoked. The two processes may proceed in parallel, provided the rights of the individual are not compromised.
- The review team's report and recommendations will be provided to any Disciplinary review.

The links between the internal review team and the Clinical Governance Structures
Relevant Clinical Governance bodies will be informed that a review has been commissioned and they will be provided with a summary of the final report detailing any recommendations and implementation plans. As far as reasonably possible the report will be anonymous in the terms of the staff, patients and carers involved.

The synopsis of the report of any review, suitably anonymised, will be circulated to staff involved to keep them informed and build their trust in the process.

Post review implementation of action points
The Review Group should ensure that any action points have lead responsibility specified and timescales clearly identified.

The Review group should agree a timescale to meet to review the implementation plan action points.

The Head of Child Protection Development will be responsible for liasing with those with lead responsibilities to ensure the implementation of action points and reporting back to the Review team on progress of these.

Timescales
Lessons should be learned and acted upon as quickly as possible.

Reviews should be completed within 4 months of the decision being made unless there is good reason for this timescale to be extended. As soon as it emerges that a review cannot be completed within this timescale the review team should agree a timescale for completion.

Debriefing for staff
At the completion of the review the officers will meet with staff to allow staff to express their feelings about the process and to discuss recommendations.

Staff will be asked to provide feedback on the process.

Support for staff
During the review process staff should feel supported by line managers and appropriate supports should be identified and put in place.

28th October 2005

APPENDIX 1 Significant Child Protection Incident Review NHSGG