Appendix B

Updated Serious Incident Notification Process

Effective from 1st Jan 2020

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1. Purpose:

The Serious Incident Notification process and the management of learning arising has been revised as set out within this paper, and now includes notifying CMT of both case and non-case related serious incidents. Following notification, the Chief Executive (CEO) decides whether to share information with the Board or the Chair, as appropriate.

2. Updated Serious Incident notification (SIN) process (case related):

2.1 Incidents will be alerted to Core CMT, both at the initial stage prior to a case review, and then following the review, with a copy of the completed SIN Case Review Form (CR1), when any of the following criteria is met:

- A child has died (including cases of suspected suicide), and abuse or neglect is known or suspected (Child was/is subject to Cafcass application)
- A child has died (including cases of suspected suicide), and abuse or neglect is known or suspected (Child is not/has never been subject to Cafcass application, for example siblings or parents known to Cafcass)
- A child has been seriously harmed and abuse or neglect is known or suspected (Child was/is subject to Cafcass application)
- A looked after child has died (including cases where abuse or neglect is not known or suspected) (Child was/is subject to Cafcass application)
- A child in a regulated setting or service has died (including cases where abuse or neglect is not known or suspected) (Child was/is subject to Cafcass application)
- Case-related anticipated press interest/national learning/social media, where Cafcass are potentially implicated or risk of organisational vulnerability
- Initial rapid review/safeguarding practice review initiated by safeguarding partner
- Death of an adult party as a result of known/suspected domestic homicide or suicide (open cases only)
- Domestic Homicide Review under consideration by Community Safety Partnership
- Child missing from care/away from placement (acute risk or risk of publicity)
- A Judgement is published or due to be published which offers learning for Cafcass
- Wasted costs applications which are assessed as high risk (over £1,000)
- Parliamentary and Health Service Ombudsman (PHSO) enquiries/investigations

- Significant learning identified in Cafcass complaint response
- Inquests into death or domestic homicide where learning has been identified for Cafcass
- Other (please specify)

2.2 At the point that a serious incident becomes known, the responsible local manager completes a Serious Incident Notification form and sends it to the Assistant Director, who adds their analysis of the situation and proposes whether the incident meets the specified criteria to share with CMT.

2.3 The form is forwarded to the Operational Director for sign off and shared with CMT as appropriate, at the same time as the National Improvement Service, who complete a review of the case (CR1) .

2.4 The CEO records the decision/rationale in respect of onward transmission to the Board or Chair only, or to request further action from the local team. The CEO may decide to await the more detailed case review before making a decision.

2.5 Following completion of the case review (CR1) the Operational Service Director signs off the report and sends to CMT.

2.6 The CEO records any final comments, actions and decision to share with the Board or Chair only, as appropriate.

2.7 The Assistant Director is responsible to ensure the actions are carried out and any learning is taken forward through the Learning Portal (see section 4).

2.8 **INTERIM PROCESS**: Until the online system is updated, a manual version is now in place using a word document initiated by the local assistant director and sent to the serious incident mailbox.

Non-case related SIN Process

2.9 A non-case process has also been established, to notify incidents affecting our staff or organisational reputation. This alerting process ensures that CMT are aware of all notifiable incidents as they happen. The new process will include criteria of what types of incidents constitute a non-case SIN, and an electronic mechanism for recording and alerting CMT (replicating features of the existing child SIN system) is being developed.

2.10 For non-case incidents, existing processes will remain, such as Health and Safety reporting, LADO referrals and management, HR systems, etc; but when the incident meets the SIN criteria, the Assistant Director or Head of Profession is required to complete the new SIN form, to add to the alerting system. Where there are existing electronic systems, the possibility for integration is being explored.

2.11 The following is a list of reportable incidents relating to serious risk to staff or organisational reputation:

a. Press interest where there is reputational risks
b. HR and risks to staff
c. Health and safety
d. LADO referrals
e. IT and cyberthreats
f. Disaster management

3. Learning Portal and Learning from SINs

3.1 A new digital mechanism is currently being developed, to pull together in one place the learning actions and outcomes from all sources. The objective is to ensure effective reflection and professional discussion of all learning outcomes that impact practice, throughout the

organisation. The Learning Portal will also ensure a clear process of reviewing learning actions, recommendations and a follow up on impact and progress.

3.2 SIN learning will feed into the Learning Portal and will follow the learning actions and outcomes process: Whenever learning is identified which is not already subject to existing policy and practice guidance, this will trigger the following actions:

3.3 Review and update of relevant training material to ensure they reflect the learning

3.4 Review and update to relevant policy and guidance

3.5 Consideration of the most appropriate method of cascading the information about the identified learning. This may be via inclusion in the monthly cascade from OMT to SAM to team meeting, or through an all user 'knowledge alert or legal alert', or through inclusion in the monthly Learning and Development or quarterly Serious Incident bulletins.

3.6 The process for testing the extent to which learning has been embedded in social work or organisational practice is that the actions recorded in the Learning Portal will become a standard item for consideration within AQRs, Performance Boards and other Quality Assurance or relevant audit activity. Operational ADs and Corporate Heads of Profession will be responsible for ensuring learning identified is embedded within practice within their area of responsibility.

4. Quarterly Organisational Learning update for Performance and Quality Committee

4.1 A report will be prepared for the Performance and Quality Committee for scrutiny of learning from serious incidents. The paper will include information for each situation where learning has been identified, provided under the following headings:

- Summary of the impact on the child
- What Cafcass did and how we did it
- Learning identified
- How the learning was addressed, both immediate and longer term
- Impact of learning on practice and evidence of this

Evidence of Learning will be reported for the following sources:

A. Serious Incidents (under the criteria in the revised process)

B. Serious Case Reviews (ready to be published)

C. Other incidents/activity in the media with the potential for learning for Cafcass

D. Best practice examples undertaken by a team or an individual

E. Published Judgements with an identified learning for Cafcass.