

**REFERRAL TO**

**EAST SUSSEX SAFEGUARDING CHILDREN PARTNERSHIP**

**OF A SERIOUS INCIDENT**

**FOR CONSIDERATION BY THE CASE REVIEW SUBGROUP**

**Section 1**

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| **Section 1 to be completed by the referring worker following a discussion with their line manager or designated safeguarding professional, and where appropriate, the Case Review Subgroup member from their agency. For agencies without a Case Review Panel representative, cases can be discussed with the Head of Safeguarding for the Local Authority – Douglas Sinclair 01273 481289.**  **This form should be countersigned by the authorising manager/professional and emailed to:**  [**ESSCP.Contact@eastsussex.gov.uk**](mailto:ESSCP.Contact@eastsussex.gov.uk)  **The objective of this form is to convey as much information that is readily available at the time of completion. If information is unavailable do not delay in making this referral.** |

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| **1. NOTIFIER DETAILS** | | | | |
| **Notifying professional:** |  | **Role** (in relation to child)**:** |  | |
| **Date of notification:** |  | **Contact details:** |  | |
| **Who are you submitting this referral on behalf of?** (please tick) | An agency  Please state: |  | A multi-agency partnership (e.g. CDOP)  Please state: |  |
| **Signed:** |  | | | |

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| **2. CHILD’S DETAILS** | | | | | | | | | | |
| **Child’s full name:** |  | | | **Other names used:** | | |  | | | |
| **Child’s date of birth:** |  | | | **Date of death/serious incident:** | | |  | | | |
| **Gender:** |  | | | **Ethnicity:** | | |  | | | |
| **Child’s home address:** |  | | | | | | | | | |
| **Where does the child live?** (please tick) | Home |  | Local authority care | |  | With relatives | |  | Other |  |
| **Child’s educational establishment:** |  | | | | | | | | | |

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| **3. PARENTS DETAILS (and other significant adults)** | | | |
| **Mother’s names:** |  | **Mother’s date of birth:** |  |
| **Mother’s address** (if different): |  | | |
| **Father’s name:** |  | **Father’s date of birth:** |  |
| **Father’s address** (if different): |  | | |
| **Details of any other significant adults and their relationship to the child:** |  | | |

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| **4. DETAILS OF SIBLINGS** | | | |
| **Name of sibling:** | **Date of birth:** | **Gender:** | **Address** (if different to key child): |
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| **5. REASON FOR REFERRAL** (please tick all appropriate options)  See guidance document for glossary of terms | |
| Considered to meet the criteria for a Child Safeguarding Practice Review (as set out in Working Together to Safeguard Children 2018) |  |
| Child has died and abuse or neglect is known or suspected to be a factor |  |
| Child has been seriously harmed (e.g. a potentially life threatening injury, serious sexual abuse) and abuse or neglect is known or suspected to be a factor |  |
| There are concerns about the way that agencies have worked together to safeguard the child |  |
| The case provides opportunities for learning lessons from multi-agency work |  |
| Child has committed suicide |  |
| Child has been a perpetrator of a serious crime |  |

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| **6. CASE OUTLINE** |
| Please give a brief summary of the events leading to the referral including any critical incident, key dates, status of child, details of any disability or communication issues and any other relevant information. |
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| **7. PARTICULAR CONSIDERATIONS** |
| Please specify any considerations for this case, for example media interest or criminal considerations or other linked cases.  If the case is known to be subject to a criminal investigation please state the lead investigator.  If the case is known to be the subject of a Coroner’s Enquiry please state key contact. |
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| **8. ANY OTHER RELEVANT INFORMATION OR ISSUES** |
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| **9. OTHER AGENCY INVOLVEMENT** | | | |
| **Agency:** | **Name and role of key worker** (in relation to key child)**:** | **Contact details** | **Reason for involvement:** |
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| **10. AUTHORISATION FOR REFERRAL** | | | |
| This form should be countersigned by the manager/professional with whom this referral was discussed. | | | |
| **Name:** |  | **Role:** |  |
| **Signature:** |  | **Date:** |  |
| **Contact details:** |  | | |

**Section 2**

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| **Section 2 to be completed by the Case Review Group** |

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| **1. MEETING** | |
| Date of Meeting: | |
| Attendees: | Documents considered: |

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| **2. RECOMMENDATION** |
| Please state whether a review is/not recommended and, where applicable what type of review is being recommended (e.g. serious case review or other learning review, multi-agency partnership review or single agency review) |
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| Please state the reasons for the panel decision. |
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| **3. AUTHORISATION FOR RECOMMENDATION** | | | |
| This form should be signed by the Chair of the Case Review sub-group. | | | |
| **Name:** |  | **Role:** |  |
| **Signature:** |  | **Date:** |  |

If the case referred meets the criteria for a review, the sub-group Chair will make a recommendation to the Independent Chair of the ESSCP who will decide whether the review should be undertaken.

**Section 3**

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| **Section 3 to be completed by the Independent Chair of the East Sussex Safeguarding Children Partnership.** |

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| **1. DECISION** |
| Please state the conclusion you have reached including the reasons for that decision. |
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| **2. ISSUES TO BE CONSIDERED** |
| Please state the issues that are of particular significance and should be considered in the Terms of Reference |
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| **3. SIGNED BY INDEPENDENT ESSCP CHAIR** | | | |
| **Name:** |  | **Role:** |  |
| **Signature:** |  | **Date:** |  |