Tower Hamlets Safeguarding Children Partnership
Executive Leadership Group

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Title of papers:
Options for Local Learning Reviews

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Reporting on behalf of:

THSCP Business Unit

Details on who has been consulted with on this paper to date:
N/A

Details of further plans for consultation:
N/A

How does this paper address/improve safeguarding children arrangements?

The paper sets out arrangements for Local Learning Reviews

How will this report item improve outcomes for children & young people?

Implementation of the new system for statutory reviews will improve how the learning from cases where a child has been seriously harmed or died from abuse or neglect is embedded. The process will be driven by the partnership and outcome focused.

Options for Local Learning Reviews

1. A key feature of the THSCP new system is the move away from Serious Case Reviews (SCR) in favour of local review. There are several guiding principles underpinning the resourcing of local reviews. The report looks at the previously published guidance for the Safeguarding Children's Partnership, specific legalisation within the Working Together Arrangements regarding statutory reviews and suggests the implementation of option for Local Learning Reviews.

1.1 As published in the THSCP arrangements the overall aims of local review are:

- To improve the safeguarding of children and young people where possible within Tower Hamlets through review of local processes, procedures and cases
- To support the delivery of high-quality services through identification of areas for improvement.
- To strengthen through proportionate candour and constructive challenge the safeguarding partnership to deliver an integrated and comprehensive offer for children and young people.
- All reviews should have an outline of estimated costs and that this is monitored on an ongoing basis to ensure overall grip on resources and timelines. All local reviews will emphasise rapid delivery of initial learning points and have clear concise recommendations.
- In response action plans will be requested from partners and these will be orientated to deliver positive mitigating actions to minimise harms encountered by those affected and inform local practice updates as a priority.
- The THSCPs sole focus is on meeting the safeguarding needs of children and young people. Individuals and agencies do not fulfil a gate-keeping function with regards to resourcing of local reviews and will not make decisions informed by budgets.
- The model of review will follow an appreciative enquiry or similar review methodology will be determined at the commission of the review and proportionate and appropriate to the context of the case under review. The Independent Scrutineer and the Recommendations and Oversight Group will consult with each other on the best model to fit the case and present this to the Statutory Partners as a formal recommendation to enable resourcing to flow to the review.

1.2 The published arrangements propose the following options for apportioning costs:

1.2.1The cost of the majority of local child safeguarding case or practice reviews will be borne by additional subscription from the Statutory Partners who have been involved in the case (mainly the Statutory Partners as the lead service commissioners). There may however be circumstances where in order to proceed a different resourcing model will be required. Joint funding decisions and disputes on local case review should not delay the delivery of a local review once it has been agreed that such a review is warranted. The decision to proceed with a local case review will be the remit of the Recommendations and Oversight Working Group.

1.2.3 In consultation with the Independent Scrutineer the THSCP may apply one of two models for apportioning local review costs to ensure equitability of resourcing impacts across the partnership. The final decision on which option is used will be agreed by consensus from the Statutory Partners in consultation and with appropriate challenge from the Independent Scrutineer.

- Option 1: The outline costs of the commissioning of the review, independent author/s, legal advice, media work will be estimated as part of the planning of the Local Review and apportioned according to agency/sector involvement in the case. The cost of dissemination of lessons will be borne as part of the Tower Hamlets Safeguarding Children Partnership Communication and Learning Working Group.
- Option 2: Applications for local review funding will in the first instance, be considered through the Statutory Partners. They will, with the support of the Strategy Manager and the Independent Scrutineer initially determine:

- If one or more Statutory Partner or Relevant Agency should bear the total cost of the review – in line with which agency is the primary responsible partner for the area of review or best placed to deliver the review;
- If more than one Statutory Partner or Relevant Agency are deemed appropriate to deliver the review then a proportional system is enacted were contributions are agreed by the Statutory Partners in consultation with the independent scrutineer with this highest level of contributions raised to a maximum of 80% of the cost of the review to ensure that all reviews have contributions from all three Statutory Partners;
- Where a relevant agency is deemed the appropriate agency to deliver the review, they will bear the cost up to 80% of the total review cost with the remaining reached through negotiation with the Statutory Partners on a shared risk pooling basis.
- Relevant Agencies will bear the costs of the attendance and contribution of their representatives and will ensure that enough time is given to members to attend meetings and undertake the work of the THSCP.

1.3 To view the full THSCP Published Arrangements click on the link: https://www.towerhamlets.gov.uk/Documents/Children-and-families services/THSCParrangements.PDF

2. Working Together Arrangements Transitional Guidance:

2.1 This section of the report contains extracts from the Working Together Arrangements as a reminder to the Executive of the guidance regarding Child Safeguarding Practice Reviews, both local and national. The working together arrangements details that "Sometimes a child suffers a serious injury or death as a result of child abuse or neglect. Understanding not only what happened but also why things happened as they did can help to improve our response in the future. Understanding the impact that the actions of different organisations and agencies had on the child's life, and on the lives of his or her family, and whether or not different approaches or actions may have resulted in a different outcome, is essential to improve our collective knowledge. It is in this way that we can make good judgments about what might need to change at a local or national"

2.2 Purpose of Child Safeguarding Practice Reviews

- "The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving;
- Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose, including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings. These processes may be carried out alongside reviews or at a later stage. Employers should consider whether any disciplinary action should be taken against practitioners whose conduct and/or practice falls below acceptable standards and should refer to their regulatory body as appropriate"

2.3 Responsibilities for Reviews

2.3.1 "When a serious incident becomes known to the safeguarding partners, they must consider whether the case meets the criteria for a local review.

2.3.2The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel (the Panel) and at local level with the safeguarding partners.

2.3.3 The Panel is responsible for identifying and overseeing the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance. The Panel should
also maintain oversight of the system of national and local reviews and how effectively it is operating.

2.3.4 **Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.**

2.3.5 The Panel and the safeguarding partners have a shared aim in identifying improvements to practice and protecting children from harm and should maintain an open dialogue on an ongoing basis. This will enable them to share concerns, highlight commonly recurring areas that may need further investigation (whether leading to a local or national review), and share learning, including from success, that could lead to improvements elsewhere.

2.3.6 Safeguarding partners should have regard to any guidance which the Panel publishes.

2.3.7 Serious child safeguarding cases are those in which:
- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed

2.3.8 Duty on local authorities to notify incidents to the Child Safeguarding Practice Review Panel."

2.4. Decisions on Local and National Reviews

2.4.1 "Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice. Issues might appear to be the same in some child safeguarding cases but reasons for actions and behaviours may be different and so there may be different learning to be gained from similar cases. Decisions on whether to undertake reviews should be made transparently, and the rationale communicated appropriately, including to families.

2.4.2 Safeguarding partners must consider the criteria and guidance below when determining whether to carry out a local child safeguarding practice review. The criteria which the local safeguarding partners must take into account include whether the case:
- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children;
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children
- is one which the Child Safeguarding Practice Review Panel have considered
- and concluded a local review may be more appropriate.

2.4.3 Safeguarding partners should also have regard to the following circumstances:
- where the safeguarding partners have cause for concern about the actions of a single agency
- where there has been no agency involvement, and this gives the safeguarding partners cause for concern
- where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around

- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings."

2.5. Commissioning a Reviewer or Reviewers for a Local Safeguarding Practice Review

2.5.1 The safeguarding partners are responsible for commissioning and supervising reviewers for local reviews.

2.5.2 In all cases they should consider whether the reviewer has the following:

- professional knowledge, understanding and practice relevant to local child safeguarding practice reviews, including the ability to engage both with practitioners and children and families.
- knowledge and understanding of research relevant to children's safeguarding issues
- ability to recognise the complex circumstances in which practitioners work together to safeguard children
- ability to understand practice from the viewpoint of the individuals, organisations or agencies involved at the time rather than using hindsight
- ability to communicate findings effectively
- **whether the reviewer has any real or perceived conflict of interest."**

2.6. Local Child Safeguarding Practice Reviews

2.6.1 "The safeguarding partners should agree with the reviewer(s) the method by which the review should be conducted, taking into account this guidance and the principles of the systems methodology recommended by the Munro review.

2.6.2. The methodology should provide a way of looking at and analysing frontline practice as well as organisational structures and learning. The methodology should be able to reach recommendations that will improve outcomes for children. All reviews should reflect the child's perspective and the family context.

2.6.3 The review should be proportionate to the circumstances of the case, focus on potential learning, and establish and explain the reasons why the events occurred as they did.

2.6.4 As part of their duty to ensure that the review is of satisfactory quality, the safeguarding partners should seek to ensure that:

- Practitioners are fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, are invited to contribute to reviews. This is important for ensuring that the child is at the centre of the process. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively;
- The safeguarding partners must supervise the review to ensure that the reviewer is making satisfactory progress and that the review is of satisfactory quality. The safeguarding partners may request information from the reviewer during the review to enable them to assessprogress and quality; any such requests must be made in writing.
- The President of the Family Division's guidance covering the role of the judiciary in SCRs should also be noted in the context of child safeguarding practice reviews."

2.7 Expectations for the Final Report

2.7.1 "Safeguarding partners must ensure that the final report includes:

- a summary of any recommended improvements to be made by persons in the area to safeguard and promote the welfare of children
- an analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report;

2.7.2 Any recommendations should be clear on what is required of relevant agencies and others collectively and individually, and by when, and focussed on improving outcomes for children.

2.7.3 Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond, so safeguarding partners must publish the report, unless they consider it inappropriate to do so. In such a circumstance, they must publish any information about the improvements that should be made following the review that they consider it appropriate to publish. The name of the reviewer(s) should be included. Published reports or information must be publicly available for at least one year.

2.7.4 When compiling and preparing to publish the report, the safeguarding partners should consider carefully how best to manage the impact of the publication on children, family members, practitioners and others closely affected by the case. The safeguarding partners should ensure that reports are written in such a way so that what is published avoids harming the welfare of any children or vulnerable adults involved in the case.

2.7.5 Safeguarding partners must send a copy of the full report to the Panel and to the Secretary of State no later than seven working days90 before the date of publication. Where the safeguarding partners decide only to publish information relating to the improvements to be made following the review, they must also provide a copy of that information to the Panel and the Secretary of State within the same timescale. They should also provide the report, or information about improvements, to Ofsted within the same timescale.

2.7.6 Depending on the nature and complexity of the case, the report should be completed and published as soon as possible and no later than six months from the date of the decision to initiate a review. Where other proceedings may have an impact on or delay publication, for example an ongoing criminal investigation, inquest or future prosecution, the safeguarding partners should inform the Panel and the Secretary of State of the reasons for the delay. Safeguarding partners should also set out for the Panel and the Secretary of State the justification for any decision not to publish either the full report or information relating to improvements. Safeguarding partners should have regard to any comments that the Panel or the Secretary of State may make in respect of publication.

2.7.7 Every effort should also be made, both before the review and while it is in progress, to (i) capture points from the case about improvements needed, and (ii) take corrective action and disseminate learning."

2.8 Actions in Response to Local and National Reviews

2.8.1 "The safeguarding partners should take account of the findings from their own local reviews and from all national reviews, with a view to considering how identified improvements should be implemented locally, including the way in which organisations and agencies work together to safeguard and promote the welfare of children. The safeguarding partners should highlight findings from reviews with relevant parties locally and should regularly audit progress on the implementation of recommended improvement. Improvement should be sustained through regular monitoring and follow up of actions so that the findings from these reviews make a real impact on improving outcomes for children."

2.9 To view the full guidance including detail on rapid review and national reviews click the link:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

3. Overview of Options for Local Learning Reviews in Tower Hamlets

3.1 Partners can decide to use one or combine multiple options to complete a review.

3.2 Options Table

Option	Overview
Single-Agency Audit	An audit will be conducted on a single agency to review multiple cases (included the subject case), this will include a deep dive into data surrounding the theme of the review and analysis of cases with a similar theme.
Multi-Agency Audit	Also known as a Live Audit within Tower Hamlets, this will be a workshop-based audit where partners from varies agencies will submit and discuss multiple cases (including the subject case) with a similar theme. Trends and learning will be explored within the audit. Data will be requested from partners involved, on specific cases and the theme of the audit. A report will be written by the chair of the audit supported by THSCP Business Unit. The chair to be a senior manager/ or a director partner agency or Independent Scrutineer.
Partner-led Workshop	A workshop will be led by a senior manager/ or director within a partner agency (an agency with no direct involvement in the case). The workshop will only focus on the subject case, all practitioners involved and managers within involved agencies will be in attendance. The workshop will explore the timeline of events, key areas of learning, and recommended actions for improvement. If the child at the centre of the is not deceased, the workshop will also focus on the future planning for that individual child.
Independently led workshop	A workshop will be led by an independently commissioned reviewer, TH Independent Scrutineer or Independent Scrutineer from a neighbouring authority. The workshop will only focus on the subject case, all practitioners involved and managers within involved agencies will be in attendance. The workshop will explore the timeline of events, key area of learning, and recommended actions for improvement. If the child at the centre of the is not deceased, the workshop will also focus on the future planning for that individual child.
Strategy Manager Report	The report will only be used when a workshop and or audit have taken place and will be used as an overview of events and learning to be implemented (learning would have been decided within workshops and/or audits).
Partner Report	A senior manager/ director from a partner agency (with support from THSCP Business unit) not directly involved in the case to conduct an in-depth review into the case, and show a timeline of events, findings, interviews with practitioners and the family and make suggested improvements and recommendations.
Independent Scrutineer Report	Independent Scrutineer to conduct an in-depth review into the case, and show a timeline of events, findings, interviews with practitioners and the family and make suggested improvements and recommendations.
Independent Author and Report	A commissioned independent reviewer to conduct an in-depth review into the case, and show a timeline of events, findings, interviews with practitioners and the family and make suggested improvements and recommendations.
Family and/or Child Engagement	A key contact (frontline practitioner) should be nominated by the partnership to brief and include the family and stay as a contact throughout the process of the report. Families should have view of the report before final draft and to be included where appropriate within the review stages. A member from the Core-Executive should

	meet with the family during the process of the review.
Children and Young People Workshop	A workshop to be held with children and young people to talk about the theme of the Local Learning Review. Such as if the Local Learning Review featured a high level of criminal exploitation, the workshop will focus solely on criminal exploitation and not the specific case. Children and young people will be asked how they feel about that specific theme in Tower Hamlets and what they think partners should do to make improvements. Workshop to be led by a nominate frontline practitioner, with support from core Exec and THSCP Business Unit.
Children and Young People Outreach	Similar to the Children and Young People Workshop, the focus will be on the themes of the review rather than the case itself. The partnership network of canvassers (those who are responsible within the partnership to gain feedback from children and young people) and THSCP business unit will go out to readily established engagement groups to discuss the theme of the review and where children and young people think the improvements should be made.

Ask of partners:

- Discuss the options suggested for Local Learning Review and make amendments;
- Consider which option(s) are best to conduct the Local Learning Review for Child MI (Attached in Appendix)