Hillingdon Safeguarding Partnership

Safeguarding Children Partnership Learning from Practice Framework

January 2022

1. Introduction

In September 2019 the Hillingdon Safeguarding Children Partnership was launched in line with the statutory requirements set out in the Children and Social Work Act 2017 and Working Together to Safeguard Children 2018. Hillingdon Safeguarding Partnership is a joint arrangement across the adult and child safeguarding networks, with a shared Executive Leadership Group. Under these arrangements The Local Authority shares responsibility with our statutory partners, the NHS North West London Clinical Commissioning Group and Metropolitan Police, to safeguard children and young people.

Following the successful implementation of the new statutory arrangements for children, the same approach has been expanded to incorporate the Safeguarding Adult Board. This has enabled Hillingdon to provide a safeguarding service that is consistent, irrespective of age, and provides opportunities for innovative and responsive services in the Borough.

A central function of the Safeguarding Partnership is to quality assure local safeguarding practice. This includes meeting statutory duties in respect of the review of serious incidents, as set out In Working Together to Safeguard Children (2018), The Care Act (2014) and the Care and Support Statutory Guidance (updated 2020). The statute places a duty on safeguarding agencies to provide information to the Safeguarding Adults Board and Safeguarding Children Partnership to enable these reviews to take place.

Hillingdon Safeguarding Partnership is committed to the development of a learning culture that:

- is open and honest
- is proportionate and avoids hindsight bias
- identifies and addresses systemic practice issues
- supports and challenges safeguarding partners to make continuous improvements to practice

It is acknowledged that the review of serious incidents is a complex and multifaceted process. This document sets out the arrangements for review of serious incidents involving children, and those circumstances where serious harm has not occurred but there is believed to be system learning.

2. Serious Child Safeguarding Incidents

> *"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 level."* (Working Together to Safeguard Children, 2018[1])

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 policy-makers. 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.

What constitutes 'Serious Harm'?

> *"Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred".* (Working Together, 2018)

[1] Working together to safeguard children - GOV.UK (www.gov.uk)

Whilst this definition provides a degree of clarity on the 'serious harm' threshold for agencies to use when considering notifying the Safeguarding Partnership, the matter is still subject to an assessment/interpretation from the Local Authority as to whether this threshold is met and it remains the case that interpretations of what constitutes 'serious harm' have to be considered on a case by case basis.

A serious child safeguarding incident is one in which it is known or suspected that a child has been abused or neglected and:

- The child dies or is seriously harmed in their area
- The child dies or is seriously harmed outside England, who is normally resident in their area

The Local Authority must notify the National Child Safeguarding Practice Review Panel of all such incidents and of any deaths of Looked After Children (whether or not abuse or neglect is known or suspected), within 5 working days of becoming aware of the incident.

Hillingdon Children and Young People's Services has embedded a Need to Know Process[2] to ensure that practitioners and managers are aware of the need to escalate any cases that may meet the criteria. Partner agencies should make contact with the Safeguarding Partnership Team in the first instance and can also submit a 'Need to Know' proforma.

The Need to Know document is reviewed, with clarity sought where required and a decision made about the need for a Serious Incident Notification. The rationale for this decision is recorded and shared with the referrer.

Where the criteria are not met for a Serious Incident Notification, but it is identified that there is value to considering the child's circumstances in closer detail the Safeguarding Partnership may undertake a learning review.

[2] Documents Library (proceduresonline.com)

3. Rapid Review

Where the criteria are met for a Serious Incident Notification a rapid review is convened within 12-13 working days. An initial scoping and information sharing document is circulated to all involved agencies to inform the Rapid Review discussion.

The rapid review is coordinated by the Safeguarding Partnership Implementation Unit and includes the following agencies:

- Local Authority – Head of Service
- Clinical Commissioning Group – Designated Nurse for Safeguarding
- Police – Detective Inspector
- Police – Serious Case Review Group
- The Hillingdon Hospital – Head of Safeguarding Families
- CNWL – Named Nurse for Safeguarding
- CNWL – Designated Paediatrician
- School/nursery
- Other relevant agencies as required

The purpose of the rapid review is to gather the available facts about a serious incident, to discuss whether there is any immediate action needed to ensure children's safety and to share any learning appropriately.

The minimum requirements for a rapid review are set out in Working Together 2018 and the 2019 practice guidance (CSPRP 2019: 14-15[3]). They include specifying which agencies have been involved in the review and who has been involved in the decision-making process; relevant identifying details of the child and family; the immediate safeguarding arrangements for any children involved; a concise summary of the facts, giving sufficient detail to underpin the analysis but without lengthy detailed chronologies 'that can obscure the pertinent facts'; a clear decision as to whether the criteria for an LCSPR have been met and on what grounds, any immediate learning already established and plans for dissemination; and the potential for additional learning.

[3] Child Safeguarding Practice Review Panel: annual report 2020 - GOV.UK (www.gov.uk)

When considering whether to undertake 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

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

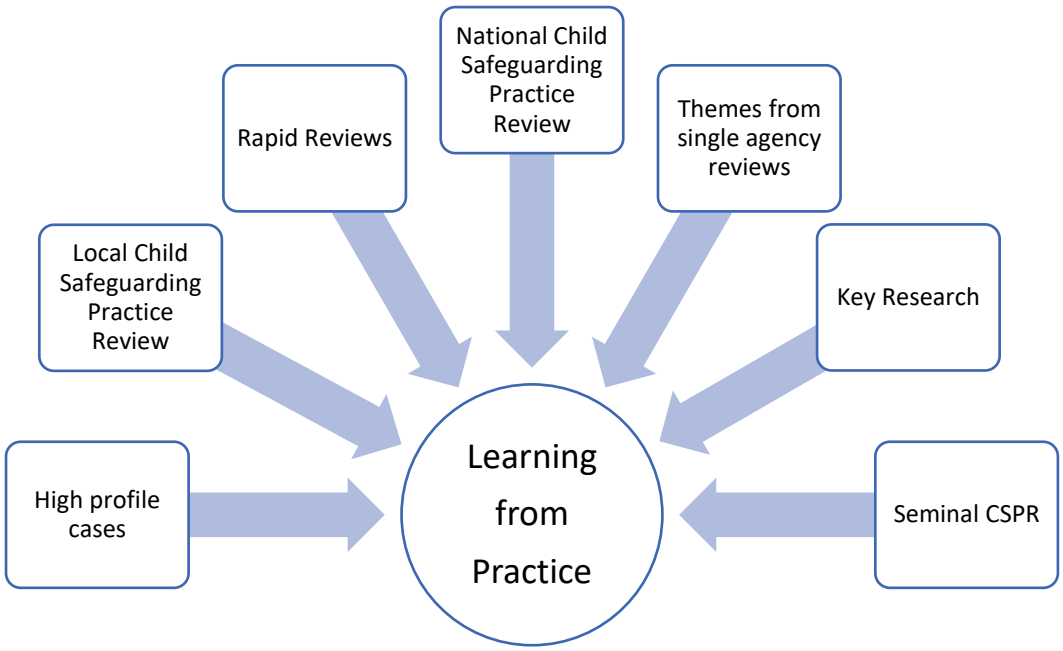
Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice. Issues 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. (Working Together to Safeguard Children, 2018)

An analysis of the child's circumstances including whether the criteria for a national or local Child Safeguarding Practice Review is sent to the Child Safeguarding Practice Review Panel (CSPRP) for ratification of local decision making. This must be sent with 15 working days of the Serious Incident Notification being made. The CSPRP provides a written outcome of consideration, advising as to the Panel's agreement, or otherwise, with local decisions. The Hillingdon Executive Leadership Group is

informed of all rapid reviews, the recommendations made, and the outcome of the Child Safeguarding Practice Review Panel consideration. Where the Rapid Review has identified areas of learning, or actions needed, in respect of local practice these will be coordinated by the Children's Learning from Practice Task & Finish Group

4. Learning from Practice Task and Finish Group

The Children's Learning from Practice Task and Finish Group coordinates the identification, consideration, and dissemination of learning from practice with children and families. The Task and Finish Group considers learning from a range of sources as outlined below:



High profile cases are identified through the Safeguarding Partnership. This element provides a framework for identifying learning from those circumstances where the criteria for a Serious Incident Notification are not met, and therefore a rapid review has not been convened. Any member of the Task and Finish Group can put forward a case for discussion using an agreed template. These are reviewed by the Group as a whole, and where there is believed to be the potential for learning for the Safeguarding Partnership a learning review can be undertaken. This is not an alternative route for escalation, the focus is on practice development and wider system learning. By exception there may be a request to progress a learning review from another subgroup.

A proportionate approach is taken within Learning from Practice, dependent on the need, complexity and circumstances of review this can include:

- the development and progression of an incident specific action plan
- a formalised learning review
- single or multiagency audit
- the dissemination of learning through briefings

The Task & Finish Group reports issues of thematic learning to the Practice Development Forum.
The Practice Development Forum leads on the planning, delivery and quality assurance of training and service development across the Hillingdon Safeguarding Partnership.

5. Practice Development Forum

The Practice Development Forum leads on the planning, delivery and quality assurance of training and service development across the Hillingdon Safeguarding Partnership. The aim of the Practice Development Forum is to ensure that high quality safeguarding training is provided across the adult and children's workforce.

The Practice Development Forum considers learning from a variety of sources and ensure that this is effectively disseminated throughout the multi-agency workforce to inform and support practitioners in the provision of effective safeguarding services to Hillingdon Residents. Sources of information include:

- Single and Multi-Agency Audits
- Statutory Inspections
- Statutory and Non-Statutory Serious Case Reviews
- Any cases of national importance or implication
- Any emerging issues of local importance
- The Child Death Overview Panel

The Practice Development Forum reports to both the Safeguarding Children Partnership Board and the Safeguarding Adults Board. This is through the maintenance of an action plan summarising key work streams, progress and any issues that need to be escalated.

There are two linked Learning from Practice Task and Finish Groups, one for adult cases and one for child cases. These groups develop and progress specific action plans, for example in response to a statutory review of safeguarding practice.

The core membership will be made up of a representative from each of the following agencies/services:

- Safeguarding Partnership Implementation Unit
- The Metropolitan Police
- Designated Nurse, Children CCG
- Designated Nurse, Adults, CCG
- Community Safety Partnership
- Education Representative
- Child Protection Lead for Education
- Adult Principal Social Worker
- Children's Principal Social Worker
- Safeguarding Children and Adults Team, NHS Central North West London Foundation Trust
- Named Nurse, Adults, The Hillingdon Hospital
- Named Nurse, Children, The Hillingdon Hospital

The Practice Development Forum meets on a quarterly basis. Where members are part of a Task and Finish Group to complete a specific piece of work the frequency of meetings will be set by the Task and Finish Group.