Meeting:	BHR Safeguarding Partnership		
Date:	15 October 2020	**Time:**	09:00 – 11:00
Venue:	MS Teams		
Chair:	Elaine Allegretti, Director of People and Resilience, LBBD		
Secretariat:	Eleanor Parkin, Partnerships and Programmes Manager, LBBD		

A G E N D A

1	Welcome, Introductions and Apologies	Chair	1 minute
2	Notes of Previous Meeting – 09 09 2020	All	5 minutes
3	Action Log 2020 - 2021	All	5 minutes
4	Update from Partners on impact and response to COVID-19	All	15 minutes
5	Joint Working with the Violence Reduction Unit (VRU) (verbal update)	AL	15 minutes
6	Themed Learning Review Consideration – Adolescent Suicide	AL/LP	10 minutes
7	Redbridge LSCB SCR Recommendations	All	10 minutes
8	BHR Case Review Guidance, Process and Forms	TDV	5 minutes
9	BHR Case Review Tracker	All	5 minutes
10	Phase 1 Report - Multi-Agency Arrangements - Expert Review by Sir Alan Wood – Next Steps	All	20 minutes
11	Agenda Forward Plan Update	All	5 minutes
12	Any Other Business (AOB)	All	5 minutes
13	Dates of Future Meetings via MS Teams • 27 November 2020 @ 10:00 • 8 January 2021 @ 15:00 • 12 February 2021 @ 10:00 • 26 March 2021 @ 14:00	All	1 minute

Meeting Information

Title:	Notes of the BHR Safeguarding Partnership Meeting
Date:	09 September 2020
Chair:	John Carroll, Detective Superintendent Safeguarding, MPS East Area BCU
Secretariat:	Lesley Perry, Manager, Redbridge SCP & SAB
Venue:	MS Teams

Attendance

Name	Title	Agency
Attendees:		
Elaine Allegretti (EA) (from 15:45)	Director of People and Resilience	LB Barking & Dagenham
John Carroll (JC)	Det. Superintendent Safeguarding	MPS East Area BCU
Caroline Cutts (CC) (for AL)	Operational Director – Children & Families	LB Redbridge
Mark Gilbey-Cross (MGC) (for JH)	Deputy Nurse Director (Acting)	BHR CCGs
Kate Dempsey (KD) for RS	Principal Social Worker (PSW)	LB Havering
Teresa DeVito (TDV)	Head of Service - Safeguarding & Quality Assurance	LB Barking & Dagenham
Lesley Perry (LP)	Partnerships Manager	Redbridge SCP & SAB
Martin Wallace (MW)	Partnerships & Learning Manager	LB Havering
Apologies:		
Adrian Loades (AL)	Corporate Director of People	LB Redbridge
Jacqui Himbury (JH)	Nurse Director	BHR CCGs
Robert South (RS)	Director of Children's Services	LB Havering

Notes

1 Welcome

JC welcomed all to the meeting. Apologies had been received as above. All agencies represented.

2 Notes of Previous Meeting – 03 08 2020

The draft notes of the previous meeting were agreed with the one amendment relating to attendance of RS.

3 Action Log 2020 - 2021

An updated version of the Action Log was presented.

Action 2020/01 - C/F – awaiting confirmation that ToR have been added to B&D SCP and Havering SCP websites.

Action 2020/07 - C/F – awaiting update from AL. Added to October agenda (TBC) and JC added to action.

Action 2020/08 - update provided by JC. Further clarification for timescale to be advised at the next meeting. C/F.

Action 2020/10 – further consideration needed by partners to the recommendations and how they apply. Clarification to be sought with Independent Chair of the Redbridge SCP on required timescale. C/F

Action 2020/11 - considered at meeting and final suite of papers, with branding, etc. to be presented to the October meeting. Content for section on CDR to be added once CDR Manager in post. C/F

Action 2020/16 – Report scheduled to be shared with CDR Manager for consideration once in post. Anticipated first week in November. C/F

4. Update from Partners on Impact and Response to COVID-19

LB Redbridge:

- All schools have reopened and majority of children have returned. The risk assessments completed by schools are generally robust and primary school staff are reminding parents/carers at the start and end of the day to be mindful of social distancing.
- Small increase in COVID-19 cases and two recent deaths, both of which are attributed to community pneumonia rather than COVID.
- Referrals into the MASH are picking up as anticipated, with an increase in the volume going directly to S47 enquiries. Concern around potential backlog of MERLINs. Requested clarification from JC on numbers and what weekends the additional staffing will be implemented so that the MASH can plan.
  Action: JC to make enquiries with DCI who oversees the MASHs and advise back to CC, KD and TDV to support planning.

LB Barking and Dagenham:

- Upward trajectory in the number and complexity of child protection referrals resulting in an increase in number of children subject to Child Protection Plans. During lockdown the numbers coming into care had dropped, but that is now beginning to rise to 'normal' levels. Number of missing children remains low.
- Every child that has a positive test for COVID is reviewed to check whether they are known to Children's Social Care.
- All schools are open. However, there have been large numbers of children being sent home following symptom identification and positive testing amongst teachers. Schools have in some cases reverted to the blanket guidance of everyone potentially exposed to self-isolate for two weeks. Some children have now returned following review. Consideration being given as to whether face coverings in secondary schools should be enforced.

LB Havering:

- Number of contacts had gone up but are now steadying. CP numbers are not going up. LAC numbers are steady.
- All schools have gone back and lots of planning has been undertaken around outbreak prevention. Expecting a surge in referrals now schools are back.

CCG:

- CDOP Manager and CDOP Administrator post holders have been recruited to and will be in post by the beginning of November.
- Recruitment to the two additional Safeguarding Adults Designated Nurses posts has been completed, with both occupants moving from provider services within the BHR footprint.
- Next focus is to increase resource in the quality assurance section of the Safeguarding Team.
- CAMHS access remains a concern following feedback from GPs and access into IAPS by adults. Commissioning colleagues are working on a project relating to Mental Health Standard Funding. A CAMHS collaborative has been set up by ELFT looking at access to Tier 4 beds across London and leading

work across pre-admission space starting on 01 October. This should provide savings which will be ploughed back into home treatment teams for children. Waiting times for CAHMS in Emergency Departments have been identified due to a variety of reasons and there is another workstream addressing this.

- CCG attendance requested at an Emergency Department Safeguarding Meeting. Waiting to hear more about the purpose of this which is likely to be around the safeguarding children agenda.
- Number of positive tests is rising across BHR but the number of deaths is declining. We may see that begin to rise along with hospital admissions. The message is not to be complacent and to continue with handwashing and use of PPE. Anticipating neuro virus and other flu strains and expectation of a second COVID wave. The CCG is seeking 100% compliance of all staff to have flu vaccines to avoid a potential massive impact across the system.

MPS

- Notting Hill Carnival in operational terms not as challenging as had been anticipated. Significant numbers of unlicensed music events across London but these were dispersed or managed appropriately.
- Safer Neighbourhood Teams are engaging with schools as they return and resources have been reviewed in anticipation of a surge in demand. Daily churn of referrals returning to near normal levels but no significant rise yet.
- Domestic Abuse levels and numbers of children exposed had increased during lockdown. These are still higher than usual. Focus is being given to dealing with DA cases promptly within the first 24 hours which has resulted in improve victim engagement and prosecution rate.
- Guidance around COVID-19 is being reviewed following the government announcement that social gatherings will be restricted from 14 September to six people from no more than two household. The four pillars of the MPS approach remain in place - Engage, explain, encourage and enforce – but there is potential that there may need to be more emphasis on enforcement if social distancing becomes too relaxed.
- Missing children numbers remain low. Pilot programme being proposed which focuses on improving engagement with LAC and care providers by the BCU, particularly with those settings that generate the highest number of missing children reports.

Action 2020/17: JC to hold meeting with RS, AL and EA to take forward.

5. Statutory Responsibilities Table

The table was agreed subject to final confirmation from AL and RS. It now reflects that any delegation of responsibility from the BHR Safeguarding Partnership to local Partnerships is to the Statutory Partners at that level.

Action 2020/18: LP and KD to clear with AL and RS. Document to then be published on local SCP websites.

6. Rapid Review/CSPR

TDV presented the suite of draft documents relating to commissioning and undertaking Rapid Reviews and Child Safeguarding Practice Reviews. Comments made at the last meeting and subsequent to that had been taken into account. There was now general agreement that decision making should be held by the statutory safeguarding partners at a local level but learning shared across the BHR Safeguarding Partnership and monitoring of progress of reviews, via the tracker. MGC pointed out that the reference to Serious Incidents could be misleading for health colleagues as this term refers to a different internal health process.

Action 2020/19: TDV to review references to SIs and make this clear, using the terminology in Working Together 2018.
Action 2020/20: MW/ LP to compare the Agency request form with those that have been used in LBR and LBH and make any further improvements or developments as appropriate.
Action 2020/21: TDV/MW/LP to work together on finalising the suite of documents and branding for hosting on the local SCP websites.
Action 2020/22: TDV to ask the new CDR Manager will be asked to develop content on the link with the CDR process, including the referral route for consideration of CSPRs to local SCPs.
Action 2020/23: LP to add to the Agenda Forward Plan for the October and November meetings.
The BHR Case Review Tracker had been brought up to date for review and monitoring. Needs to be maintained as a 'live' document.
Action 2020/24: LP to add as a Standing Item to the Agenda Forward Plan.

7. Response to Recommendations from the Redbridge LSCB SCR Review Report

The recommendations made in the **Redbridge LSCB Serious Case Review (SCR) ' Baby T' Report** specifically to the BHR Safeguarding Partnership were presented in table form with actions allocated to each agency. It was agreed that more time was needed to consider the implications for each.
Action 2020/25: any comments to be made to LP between meetings and to be added to the Agenda for the next meeting for sign off.
Action 2020/26: LP to clarify with Independent Chair of the Redbridge SCP any concerns around timescale for taking forward the recommendations.

8. Adolescent Suicide – Possible Themed Review

CC provided a brief overview of the case of an adolescent suicide in June, on which a Rapid Review had been undertaken and the report sent to the National Panel. The Panel had agreed with the conclusion made by the local safeguarding partners that a CSPR was not appropriate but encouraged exploration of a themed adolescent suicide review. Partners were asked to consider the value in a review and if there was merit, whether this should be conducted by the Partnership or recommended as an action for CDR.
LP had provided data for the period March 2019 – August 2020 on suicides which involved low numbers. MPS were working on the data they held on suicide attempts but this was problematic as there was no automatic flag and two systems (CAD and MERLIN) had to be interrogated. The rough data set had identified 21 attempts for LBR; 23 for LBH; and 26 for B&D. This data had to be verified. There were also issues with how an attempt was defined and interpreted and also whether they were incidents that happened within BHR but the individual children could live outside of the footprint.
EA supported exploring a themed review and felt that there were significant challenges currently with the mental health services available to adolescents, particularly those experiencing transition from children to adult services. She felt it was worth looking at the 18 – 24 pathway collaboratively. JC agreed that a focus on transition would be worthwhile.
LP advised that NELFT had undertaken a themed review recently across a wider footprint and had identified a trend with young people with ASD. She had asked if the learning could be shared. There was also the learning from the Internal Learning Reviews (ILRs) undertaken in Redbridge on two adolescent suicides last year.
LP advised that the conclusion of the Rapid Review that had instigated the discussion did not find that there were issues with CAHMS service provision offered and transition didn't feature. MW confirmed that neither were these issues in the LBH suicide.

MGC said that the National Confidential Inquiry into Suicide and Safety in Mental Health is likely to have covered issues such as transition, which we wouldn't want to repeat if there is learning there already. He felt that looking specifically at adolescent suicide relating to COVID is too early as we are still in the pandemic.

Action 2020/27: LP/CC to take away and look at whether there are sufficient gaps in learning that could be addressed in a BHR themed review and bring back to the October meeting for a decision.

9. Agenda Forward Plan Update

The current version of the Agenda Forward Plan for the remaining meetings for 2020 – 2021 was reviewed and updated.

10. Any Other Business

- No AOB.

11. Dates of Future Meetings

Meeting dates had been agreed as follows:

- 15 October 2020 @ 09:00 – Chair – EA Secretariat Eleanor Parkin (LBBD)

Action 2020/28: dates to be set for the remainder of the year to March 2021 at six weekly intervals by LP/MW/TDV

BHR Safeguarding Partnership Action Log 2020 - 2021			
Date	**Action**	**Lead**	**Update Comments**
Meeting: 05 June 2020			
2020/01	Partnership ToR to be published on individual Local Safeguarding Children Partnership websites.	Partnership Managers	Published on the Redbridge SCP website. C/F – awaiting confirmation from B&D SCP and Havering SCP.
2020/02	Statutory Responsibilities Table to be completed in draft and any areas requiring further discussion to be identified between meetings. Final draft to be presented for approval to July meeting.	Partnership Managers	Final draft on Agenda for meeting held on 03 08 2020. Close.
2020/03	Outcomes, findings and learning from Rapid Reviews and Child Safeguarding Practice Reviews to be scheduled as an Agenda item every six months.	Partnership Managers	Item added to the forward plan for December 2020 meeting. Close.
2020/04	Domestic Abuse presentation by Partners to be added to the agenda for the July meeting covering current offer, impact of interventions, what is working well and what could be further developed.	All	Item added to Agenda for meeting held on 03 08 2020. Close.
2020/05	Exploration of Tier 4 CAHMS self-harm and eating disorders explored – agenda item for July meeting.	All	Item added to Agenda for meeting held on 03 08 2020. Close.
2020/06	Updates from partners on the impact and response to COVID-19 to be added as a standing agenda item for Partnership meetings.	Partnership Managers	Item added to the Agenda Forward Plan for each meeting during 2020 – 2021. Close.

2020/07	Violence Reduction Unit (VRU) to be approached to develop work with the partnership and item to be scheduled for a future meeting.	Adrian Loades/John Carroll	Approach made by AL to VRU but no response received yet. Item subject to confirmation – added to Forward Agenda Plan for October subject to confirmation. C/F
2020/08	Information relating to MPS Prevent referral form trial to be circulated and then discussed outside of meeting with Borough leads.	John Carroll	Pilot in LB Hillingdon, LB Hammersmith and Fulham and LB Kensington & Chelsea was to be re-started following suspension for COVID and school holiday. Form under review to ensure any changes relating to COVID are incorporated. JC to seek clarification of new timescale from MPS lead. C/F
2020/09	Partnership meetings to be scheduled every six weeks by with rotating chair – next two meetings covered by BCU and CCG.	Carol Hale	Meetings booked for 03 08 2020 (Chaired by MGC); 09 09 2020 (Chaired by JC); and 15 10 2020 (Chair – EA - TBC). Close.
Meeting: 03 August 2020			
2020/10	Recommendations from the Redbridge LSCB SCR to be put into table format identifying which applies to each agency and at local or BHR Safeguarding Level.	AL/LP	Presented to meeting on 09 09 2020. To be reviewed between meetings for sign off at October meeting. Clarification to be sought from Independent Chair, Redbridge SCP on appropriate timescale. C/F
2020/11	Comments on Rapid Review/CPSR documents to be provided by TDV by 14 08 2020.	All	Final suite of papers to be presented to the October meeting. Content for section on CDR to be added once CDR Manager in post. C/F
2020/12	Rapid Review/CPSR tracking document to be provided as an example for adaptation.	TDV	Completed 03 08 2020.
2020/13	Multi-Agency Audits – item to be added to the Agenda for October.	LP	Completed 03 08 2020.
2020/14	Information on LBR Reach Out Service to be circulated.	Al	Completed 03 08 2020.
2020/15	Information on LBH response to Domestic Abuse to be circulated.	KD	Completed 09 09 2020.

2020/16	Report on SUDI to be forwarded to CDOP/CDR Manager once in post for considered by CDOP.	MGC	CDR Manager due in post at the beginning of November. Report will be passed on then. C/F
Meeting: 09 September 2020			
2020/17	Meeting to be held between BCU and Borough leads to consider project of engagement with LAC and care home providers in relation to missing.	JC	
2020/18	Statutory responsibilities table to be cleared via AL and RS and then published on local SCP websites.	KD/LP/TDV/MW	LP e-mailed to AL on 10 09 2020.
2020/19	Review references to SIs to clarify for health colleagues, using the terminology in Working Together 2018.	TDV	
2020/20	Compare the draft Agency request form with those that have been used in LBR and LBH and make any further improvements or developments as appropriate.	LP/MW	
2020/21	Finalisation of the suite of documents and branding for hosting on the local SCP websites.	TDV/MW/LP	
2020/22	CDR Manager to be asked to develop content on the link with the CDR process, including the referral route for consideration of CSPRs to local SCPs.	TDV	
2020/23	Review Documents to be added to the Agenda Forward Plan for the October and November meetings.	LP	Completed 09 09 2020.
2020/24	Case Tracker to be added as a Standing Item to the Agenda Forward Plan.	LP	Completed 09 09 2020.
2020/25	Comments on the recommendations to be made to LP between meetings and to be added to the Agenda for the next meeting for sign off.	All	
2020/26	Clarify with Independent Chair of the Redbridge SCP any concerns around timescale for taking forward the recommendations.	LP	E-mail sent to Independent Chair on 09 09 2020. Awaiting response.
2020/27	Consideration of whether there are sufficient gaps in learning that could be addressed in a BHR themed	LP/CC	

	review and bring back to the October meeting for a decision.		
2020/28	Dates to be set for the remainder of the year to March 2021 at six weekly intervals.	LP/MW/TDV	
Meeting: 15 October 2020			

Title:	Briefing – Adolescent Suicide Research and Learning Reviews
To:	BHR Safeguarding Partnership
From:	Lesley Perry, RSCP & RSAB Manager
Date:	15 October 2020

1. Introduction

This briefing paper provides information to the Partnership on the available research and learning review reports relating to adolescent suicide. The purpose of the briefing is to inform decision making on any potential gaps in information and merit in commissioning a themed learning review on the topic across the Barking & Dagenham, Havering and Redbridge (BHR) 'footprint'.

There is a high volume of different reports and research on the subject to adolescent suicide and even more on adolescence mental health. This briefing is a limited summary of the most recent and relevant.

2. Background

An area of discussion arising from a recent Rapid Review undertaken by the Redbridge Safeguarding Children Partnership (RSCP) on behalf of the statutory safeguarding partners. the Rapid Review related to the case of a male adolescent who died through suicide. The case did not reach criteria for a Child Safeguarding Practice Review (CSPR), consideration was being given as to what could be gained from conducting a themed review of adolescent suicide. Whilst this case did not raise any concerns around availability of services, and did not relate to transition from children to adult mental health services, these were areas that it was thought it worth exploring if they had not been covered in recent reviews or research conducted elsewhere, from which lessons could be learnt.

3. Data

As presented to the last Partnership meeting, data collated from our Boroughs has identified 5 adolescent suicides during the period 01 March 2019 to 01 September 2020 (two subject to inquest confirmation), of which three were open to CAMHS. Data relating to attempted suicide has been limited from the Boroughs but the BCU are working towards providing this.

There is already data available via he National Child Mortality Database (NCMD) in the report Child Suicide Rates during COVID-19 Pandemic July 2020. The national data, collated from Child Death Overview Panel (CDOP) reports (page 9), indicates a slight but statistically insignificant rise in the number of suicides so far. In the 82 days preceding lockdown (01 January – 22 March 2020) there were 26 and in the 52 days of lockdown (23 March – 17 May 2020) there were 25, of which 68% had current or previous contact with mental health services. The list of potential COVID linked issues include restrictions to education and other activities; disruption in care services; tensions at home; and isolation. There is no specific mention of issues relating to Tier 4 CAMHS resources nor transitions to Adult Mental Health Services, however the report advocates specific focus on provision of

mental health services to adolescents during COVID-19. It is likely, however, that the full impact will not been known until much later, particularly as local lockdowns are experienced.

4. Literature Review

4.1 Case Reviews

There is learning available from several case reviews undertaken locally on adolescent suicide.

Redbridge SCP undertook an Internal Learning Review (ILR) earlier this year on two cases of adolescent suicide pre-COVID. Both concluded that the incidents could not have been predicted. Recommendations were made on development of cultural literacy and competency; the importance of historical context; promoting professional challenge; supporting professionals during times of trauma; and consideration of resilience of children that have experience multiple transitions and trauma.

More recently Redbridge SCP carried out a Rapid Review on another case that had happened during COVID. Again, the conclusion was that the incident could not have been predicted and the individual had been receiving support. The Report which was submitted to the National Panel has been shared with the Partnership.

The National SCR Repository, facilitated by the NSPCC, contains all published Reviews. It produced a summary guide Suicide: Learning from Case Reviews in 2014 which draws on the themes and learning from SCRs undertaken between 2010 and 2014. Learning from four individual adolescent suicide SCRs published this year is also available i.e. Harry (2020) – attempted suicide; Child K (2020) – suicide; Sasha (2020) – suicide; Carys (2020) – suicide;

There is also a summary guide CAMHS: Learning from Case Reviews from 2017 which looks at cases where children open to CAMHS have died or been seriously harmed as a result of suicide, self-harm etc. which includes a section on managing transitions.

4.2 Themed Reviews

NELFT undertook a themed Learning Review – Adolescent Suicide earlier in the year. This related to cases outside of the BHR 'footprint'. A copy of the report or the learning has been requested (September 2020).

Kent Multi-Agency Safeguarding Children Partnership Executive Summary of a report Suicide in Children and Young People: A Themed Analysis, August 2020, was undertaken following 16 suspected cases of suicide of young people in Kent between 2014 and 2018. It is based on data from those cases and several individual case reviews. The report is not published, but is shared with this Briefing, the findings of which are on pages 2 and 3 – 1.4.2 to 1.4.9.

There has been some discussion that the next National Panel review may be on the theme of adolescent suicide but there is currently no confirmation of this.

4.3 Research

Extensive research had been undertaken on adolescent suicide and mental health. Below are some examples.

Title	Mental Health and Well-Being Surveillance Report	**Publication Date**	September 2020
Publisher	Public Health England (PHE)	**Link**	https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report
Summary	Includes sections on thoughts of death and self-harm and actual incidences. Section on children and young people with weekly tracking information on themes of anxiety, depression, and stress.		

Title	Predictors of future suicide attempt amongst adolescents with suicidal thoughts or non-suicidal self-harm: a population based birth cohort study.	**Publication Date**	March 2019
Publisher	The Lancet	**Link**	https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30030-6/fulltext
Summary	Considers the move from self-harm and suicidal thoughts suicide. Strongest predictors were linked to drug misuse, personality type. Useful comparison with studies undertaken during COVID.		

Title	Transition from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS)	**Publication Date**	July 2018
Publisher	Health Safety Investigation Branch (HSIB) – funded by the Department of Health & Social Care and hosted by NHS England and NHS Improvement.	**Link**	Full Report (84 pages): https://www.hsib.org.uk/documents/43/hsib_report_transition_from_camhs_to_amhs.pdf Summary Report (10 pages): https://www.hsib.org.uk/documents/44/hsib_summary_report_transition_from_camhs_to_amhs.pdf

Summary	This includes a case study of a young person who died by suicide shortly after transitioning from CAMHS to AMHS.
Other information	Who is in the transition gap? Study of transition from CAMHS to AMHS in the Republic of Ireland identified that as significant an issue as referrals not being made to adult services was the refusal by older adolescents to take up AMHS. The Royal College of Psychiatrists offer guidance and resources on transitions for parents, carers and children. SCIE offer guidance and resources for practitioners – including risks around disengagement during transition and barriers to effective transition.

Title	**National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)**	**Publication Date**	2017
Publisher	University of Manchester	**Link**	http://documents.manchester.ac.uk/display.aspx?DocID=37566
Summary	Includes the broader age range of adolescents up to and including 25 years based on data collated since 1995. NCISH is providing resources and guidance on preventing adolescent suicide during COVID including learning and development opportunities, reference material and information on changes in modes of access for help.		

Title	Inpatient Provision for Children and Young People with Mental Health Problems	**Publication Date**	2017
Publisher	Education Policy Institute	**Link**	https://epi.org.uk/wp-content/uploads/2018/01/EPI_Inpatient-care_mental-health.pdf
Summary	Covers capacity and appropriateness of facilities for adolescents.		

Research is beginning to emerge on the theme of coronavirus and child mental health although it is too soon to analyse the full impact and data relating to adolescent suicides linked to the pandemic including lockdown.

Title	**Coronavirus: child mental health**	**Publication Date**	September 2020
Publisher	Co-SPACE	**Link**	Report 05: changes in children and young people's mental health symptoms and 'caseness' during

			lockdown and patterns associated with key demographic factors (PDF)
Summary	Findings from the report looking at changes in children and young people's emotional, behavioural and attention difficulties include: the emotional and attention difficulties were consistently elevated among children and young people from low income households through lockdown compared to those from higher income households, with around two and a half times as many children experiencing significant problems in low income households.		

5. Resources – Post Suicide

There are a number of resources that could be promoted more widely supporting families and practitioners following a suicide. For example, the LGA Support after Suicide: A guide to providing local services. For families, the NHS Help is at Hand booklet. The Papyrus guide Building Suicide Safe Schools and Colleges – a Guide for Staff covers prevention, intervention and postvention (response to suicide). Individual agencies do need to have in place support for professionals, including counselling and additional supervision, when they experience the suicide of a young person they have been working with.

6. Options for Future Steps

The options available depend on the questions that we want answered, which will inform the focus of any future reviews or work. The areas of concern raised at the last Partnership meeting were any additional risk during transition from CAMHS to AMHS and availability of Tier 4 services. However, these are not issues identified in any of the recent Internal Learning Reviews nor Rapid Reviews.

Future steps could include:

- Commissioning an audit, as part of the BHR Safeguarding Partnership audit programme, on cases in transition and/or Tier 4 level of need if those are the particular areas of concern;
- Request a report from NELFT on the issues of concern to seek assurance;
- Commissioning a themed review and learning event led by the BHR CDOP whose purpose is to focus on local and national learning from cases (see Child Death Review Statutory and Operational Guidance (England), with lessons learnt and actions taken included in the annual report for CDR partners;
- As a member of Research in Practice (RiP) and Making Research Count (MRC), London Borough of Redbridge could request themed reviews on this topic as future focus of resources, literature review and learning activities;
- Commissioning a themed review with a learning event, supported and funded by the BHR Safeguarding Partnership subject to capacity and availability of resources.
- Use the Kent Multi-Agency Safeguarding Partnership Themed Analysis Report nine findings to inform an action plan for the BHR footprint.
- Consideration of the effectiveness of current borough based suicide prevention strategies. Public Health England published a Local Suicide Prevention Tool in September 2020 which could be used alongside the LGA Suicide Prevention Guide for Local Authorities.

Kent Safeguarding Children
multi-agency partnership

Suicide in Children and Young People - Thematic Analysis

August 2020

Dr Terence Nice
BSc MSw MSc MA PGCHE

Executive Summary

The purpose of this Executive Summary is to highlight the report's strategic points, key findings and multi-agency recommendations.

1. Origins of the Study and Research Question

1.1.1 In Autumn 2018, the Kent Safeguarding Children's Board made the decision to undertake a thematic review of Teenage Suicides to discuss ideas, thoughts and research strategies following a rise in the number of adolescent suicides in Kent, which reflected a rise in adolescent suicides nationally. A Review Panel was established to coordinate and oversee the thematic review, and it was agreed that Dr Terence Nice (Programme Director and Lecturer in Psychological Studies, University of Kent) be commissioned to undertake the review.

1.1.2 A key area in the Panel's opening discussions was an influential report from Manchester University entitled: Suicide by Children and Young People: Manchester Report (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness), (NCISH, 2017).

1.1.3 The focus of these initial Panel meetings was to identify a strategic, workable and ethical research pathway that would enhance our understanding and knowledge of youth suicides in Kent. It was deemed important that the outcome of the study should not be a theoretical enterprise, but deliver a set of practice recommendations that could inform a multi-agency learning programme and identify any themes and patterns underwriting the suicide process.

1.2 Aim and Objectives

1.2.1 This review undertook a statistical data analysis of existing reports relating to the suspected suicides of 16 young people in Kent between May 2014 and June 2018. This was complemented by a Thematic Analysis of four cases (anonymised for reasons of confidentiality and data protection). The reports consisted of three Root Cause Analysis (RCA) Reports and two Local Safeguarding Board reports detailing multi-agency involvement with the young people and their families. A total of five reports were subjected to thematic analysis.

1.2.2 Aim

- To gain a wider understanding of the issues experienced by young people that led to them taking their own lives.

1.2.3 Objectives

The objectives of the review were to:

1. To identify principal themes and patterns pertaining to attempted or completed suicide
2. To assist in the raising of staff awareness of early indicators where young people may be vulnerable to self-harm and/or suicide ideation
3. To assist in the identifying of appropriate services to support young people at the earliest possible opportunity.

1.3 Method

Two methodological approaches were adopted:
1) Comparative Statistical Analysis;
2) A Thematic Analysis.

1.4 Key Findings

1.4.1 The key findings of this report are summarised below. The report also includes specific recommendations for the Multi-agency Partnership.

1.4.2 The General Practitioner (GP) is often the first port of call for young people suffering with mental health issues or disorders, and is in a unique position to assess the young person, delivering specialist advice and onward referral to Child and Adolescent Mental Health Service (CAMHS). This places them in a unique and important position in accessing timely, necessary and requisite services. How we bring them on board and support them to be a part of a multidisciplinary holding environment is the next challenge.

1.4.3 The interface between different specialist health services and other organisations is a vital, but vulnerable line of demarcation, and may be decisive in determining effective service response and blue-light actions. Whether this is seamless, integrated or obstructed will determine timely or delayed service response within the suicide trajectories of young people. How one removes these barriers to service is worthy of discussion and action.

1.4.4 Long waiting lists, poor lines of communication and administrative errors can lead to a delay in urgent assessments of self-harming and suicidal young people. Suicidal young people cannot wait, they require urgent assessment and preventative interventions and evidenced-based treatments commensurate with the severity of their presentation.

1.4.5 Quality of assessment and early treatment is indicated in the diminishment of risk and meeting the complex needs of young people. Suicidal ideations and suicidal plans may not be a reliable indicator of chronic intent to commit suicide, therefore, a comprehensive assessment is required involving actively listening to parents and young people, cross-checking and cross-referencing at an individual and systems level. What constitutes a gold-standard assessment which keeps young people protected and safe in the heart of their families is a question worthy of further exploration.

1.4.6 In this review, in the context of family systems, the mother is the parental figure who appears to notice small behavioural nuances and changes in child's behaviours. This may of course also extend to fathers, but this is not demonstrated in this review. She may act as a systems barometer or sensor, picking up feelings and behaviours that otherwise may go unnoticed. Bringing parents' experiences to the table is vital in creating preventative strategies. For example, parents of young people who have committed suicide have advocated improved mental health training for teaching staff.

1.4.7 The 'Rising Tide of Risk and Concern' theme suggests that there is a suicide trajectory, wherein opportunities exist to prevent suicide. This review found that whilst single and 'Discrete Trigger Events' (DTEs), may account for a tipping point, consideration should be given to a 'Trigger Event Phase' (TEPs), that may capture deterioration in presentation and a sea change in individual presentations and suicidal intent.

1.4.8 A greater understanding of protective factors is warranted, not only as discrete entities, but in how they combine and interact to form a protective membrane around the young person.

1.4.9 Consideration should be given to how to support family survivors of suicide in a respectful, timely and appropriate manner.

1.5 Implications for Practice

1.5.1 The overview data shows that most of the young people were known to services, primarily CAMHS, and that most had communicated concerns about suicide in the form of a previous attempt, an episode of self-harm or suicidal ideation. These cases accord with the strong connection in the research literature between self-harm and suicidal thoughts, ideas and threats, and repeated self-harm and completed suicide. The key implication for practice, and one which might be challenging for services, is that evidence of suicidal concerns needs to be responded to, not with a risk assessment that distinguishes on the basis of method and stated intent, but with a comprehensive and immediate psychosocial assessment and engagement in a therapeutic relationship. This is also the recommendation of the National Institute of Clinical Excellence (NICE) 2011. The challenge is clear to ways of working, common assumptions and, not least, the deployment of resources.

1.5.2 Alongside this, a second practice implication is the importance of addressing the issues faced by identifying the young people, who constitute a minority in this study, and who do not come directly to the attention of mental health services or social care, for mental health and suicidal communications, but who do raise concerns in mainstream services, education, primary care, and amongst family members and peer groups. Inter-professional sharing is crucial, alongside the need for training for the wider professional network. Community focused approaches to suicide prevention are indicated, for which several examples now exist. Additionally, professionals need to have greater awareness of and the capacity to explore young people's use of online activity and social media.

1.5.3 A third practice implication in this review is the role of GPs, who often represent a first port of call for suicidal young people and their families. This is a vital link in the chain especially in bridging the vulnerable lines of demarcation between other professional services. The importance of bringing GPs on board has implications for practice at a multiplicity of levels, assessing the needs, risks and resilience of young people, onward referral and ensuring that family concerns are given the requisite response in an urgent or timely manner. In this way they are a vital part of a network system that should calibrate and hold 'concern, risk and need' in an integrated fashion that is spread across all professional agencies and charitable organisations. Training is required to identify ways in which these demarcation lines can be effectively bridged.

1.5.4 Fourthly, in systems and organisations where there is over-whelming demand, limited resources and poor or broken lines of communication, consideration needs to be given to bridging these lines of vulnerability. There can be no short-cuts or abridged assessments, especially given that absence of suicidal ideation or suicide plans may not indicate genuine suicide intent. These issues have often been a cornerstone to clinical assessment and therefore, revisiting what constitutes an effective gold-standard assessment is important and should be guided by the recommendations of NICE, 2011; 2017). Moreover, assessors have often focused upon single event triggers rather than TEPs that capture the rising tide of

risk and need in the context of systems and a cumulative suicide trajectory. Attention in RCA reports centre on 'risk', with the odd reference to protective factors. The identification of authentic protective factors is a piece of work that may produce some benefits in informing our understanding of adolescent suicides.

1.6 Summary

1.6.1 The findings of this regional review confirm wider UK national trends surrounding adolescent suicides in terms of age, gender, method and other suicide correlates, such as self-harm, bereavement, depression, social withdrawal and loss (NCISH, 2017). National statistics indicate a significant rise in young male suicides in 2018, and the suicide rate among females aged 10 to 24 years has increased significantly to its highest recorded level since 1981 (ONS 2018). Important areas were identified and highlighted in relation to young people's contact, access and disengagement with services. Long waiting lists, poor access to services and broken communication pathways were a common feature across the four cases. It was found that assessment of suicide risk and need warranted a comprehensive assessment framework (NICE, 2011), that did not skirt over the issues of ideation, intent, plan and method. There could be no abridged assessments or short-cuts in assessing suicidal young people irrespective of motivation or stated intent. The pivotal role of GPs was recognised as a 'first port of call' and the need for inter-professional collaborations in facilitating a holding network which can share vital information is indicated.

1.6.2 In meeting the overall aim and review objectives, an important construct was generated relating to the 'rising tide of risk and concern' and how this theme informed understanding of a deterioration in mental health and the suicide process. The shift from suicidal ideations to suicide, could be usefully conceived as a TEP, with a fluidity that rises and falls as opposed to a DTE. The two are not mutually exclusive, but a discrete trigger event may give the finer detail of suicide process. TEPs allows for a bigger picture of the shifts, movements and dynamics underwriting suicide process that may counter the idea that suicides seemingly 'come out of the blue.' More research grounded in young people's experiences and their use of social media is required to map these tides and patterns, accepting the uniqueness of the individual's own suicide narrative and the patterns and phases that run through young people's suicides. These themes and patterns are repeated in constructs such as age, gender, ethnicity, bereavement, e-bullying, Lesbian, Gay, Bisexual, and Transgender (LGBT) issues, social media, psychiatric disorders, emotional well-being and self-harm. If, as researchers and clinicians, we narrow our visual range to solely focusing upon 'risk', we will construct an edifice built upon weak foundations that ignores the needs, resilience mediators and protective factors that speak of positive survival and a fulfilling life.

1.7 Recommendations

1. For GPs and school teaching staff to be an integral part of the inter-professional holding network and receive training commensurate with this role.
2. Professionals need to have greater awareness of and the capacity to explore young people's use of online activity and social media.
3. Professionals, where suicidal concerns are identified, need to respond with a comprehensive and immediate psycho-social assessment of the young person and their engagement in a therapeutic relationship.
4. Increase professionals' understanding of the processes that drive young people to take

their own lives.

5. Resources should be promoted to identifying protective factors that combine and foster a protective membrane around the young person and their family.
6. Consideration should be given to timely and proportionate access to mental health services with emphasis on direct positive engagement, comprehensive assessment and necessary treatments with young people and their families.
7. Listening to and learning from Children and Young People and their Families must be used in creating preventative suicide strategies that are credible

1.8 Next Steps

1.8.1 To maximise the impact of this review and to capitalise on the collective energies and collaborations of different parties engaged in this review, further research might conceivably bring clinicians, front-line workers, families and young people together to share their lived experiences of attempted suicide. For some young people, their voices and stories will never be heard; but for the survivors of suicide it is important that as professionals and practitioners, we listen and learn from their experiences. This might be conducted through a series of forums or through a set of focus groups, which identify the interplay of risks, needs and protective factors that characterise suicide. This review represents one step on the road to understanding adolescent suicide and on the onward journey, there are many steps to come and there is much to learn.

Recommendations from Case Reviews for BHR Safeguarding Partnership			
Case Type:	Serious Case Review (SCR)	**Publication Date:**	14 01 2020
Lead LSCP:	Redbridge SCP	**Title and link to Report:**	Redbridge LSCB Serious Case Review (SCR) – Baby 'T'
Comments:	The Report which was presented to and accepted by the Redbridge LSCB at its last meeting in October 2019 contained 19 recommendations, 11 of which were for the BHR Safeguarding Partners. The other recommendations have been acted upon at local level by the RSCP.		

Recommendation	Redbridge SCP	B&D SCP	Havering SCP	East Area BCU MPS	BHR CCGs	BHR Safeguarding Partners
BHR Safeguarding Partners write to the Home Office in support of their recommendation that asylum-seeking mothers and their baby are never moved before the child is eight weeks old or the relevant clinician confirms that essential core postnatal care has been completed, whichever is the longer.	Redbridge SCP to draft letter.	N/A	N/A	N/A	N/A	Letter to be signed by BHR partners – draft available at meeting on 15 10 2020.

Recommendation	Redbridge SCP	B&D SCP	Havering SCP	East Area BCU MPS	BHR CCGs	BHR Safeguarding Partners
BHR Safeguarding Partners considers the provision of enhanced training on the complexities of the asylum system to practitioners involved in providing support to asylum seekers and their children.	LBR Learning & Development /RSCP training function develops provision aimed at…. and offer is made available to BHR partners.	Promote training.	Promote training.	Promote training.	Promote training.	BHR partners to promote training.
BHR Safeguarding Partners share this SCR report with the London Safeguarding Board so that the provision of enhanced training on the complexities of the asylum system to practitioners involved in providing support to asylum seekers and their children can be considered by other London Boroughs.	Redbridge SCP to draft letter.	N/A	N/A	N/A	N/A	Letter to be signed by BHR partners – draft available at meeting on 15 10 2020.
When the BHR Safeguarding Partners disseminate the learning from this case to practitioners the potential benefits of sharing information with asylum accommodation providers is highlighted.	Redbridge SCP to develop a learning slide pack. Promote the learning slide pack across all agencies working with children, young people and families.	Promote the learning slide pack across all agencies working with children, young people and families.	Promote the learning slide pack across all agencies working with children, young people and families.	N/A	Promote the learning slide pack across health providers.	Learning slide pack in development by RSCP Training Manager. To be published and disseminated when available.

Recommendation	Redbridge SCP	B&D SCP	Havering SCP	East Area BCU MPS	BHR CCGs	BHR Safeguarding Partners
When the BHR Safeguarding Partners requests NHS England to emphasise the importance of obtaining comprehensive information from pregnant asylum seekers and asylum seekers with infant children to all GP practices in England.	Redbridge SCP to draft letter.	N/A	N/A	N/A	N/A	Letter to be signed by BHR Safeguarding Partners – draft available at meeting on 15 10 2020.
BHR Safeguarding Partners share this SCR Report with the Safeguarding Children Partners in the London Boroughs of Hackney and Croydon and in Cardiff so that they can consider the report and advise of any needs for improvements in practice which they identify, and the action they propose to take.	Redbridge SCP to draft letter.	N/A	N/A	N/A	N/A	BHR Safeguarding Partners to write to relevant Safeguarding Children Partners - – draft available at meeting on 15 10 2020.
When disseminating the learning from this SCR, BHR Safeguarding Partners ensure that the key issues for practitioners to take into account when assessing the risks that parental mental health could present to any child within the	Redbridge SCP to develop a learning slide pack. Promote the learning slide pack across all agencies working with children, young people and families.	Promote the learning slide pack across all agencies working with children, young people and families.	Promote the learning slide pack across all agencies working with children, young people and families.	N/A	Promote learning slide pack across health providers.	Learning slide pack in development by RSCP Training Manager. To be published and disseminated when available.

Recommendation	Redbridge SCP	B&D SCP	Havering SCP	East Area BCU MPS	BHR CCGs	BHR Safeguarding Partners
household are prominently included.						
BHR Safeguarding Partners develop and implement as a matter of priority a strategy for improving the availability of effective interpreting services across the London Boroughs of Barking and Dagenham, Havering and Redbridge.	Consult with LBR Commissioning and Contract Manager to review contract with Language Shop – e-mail sent on 20 09 2020.	Is this an issue in LBBD?	Is this an issue in LBH?	Is this an issue for MPS?	Is this an issue for GPs and other health providers e.g. NELFT across BHR?	N/A
BHR Safeguarding Partners seek assurance that advice to parents on caring for crying and sleepless babies is accessible in all community languages.	Information and signposting to be made available on RSCP website.	Information and signposting to be made available on B&D SCP website.	Information and signposting to be made available on HSCP website.	N/A	Ensure providers of Primary Care, Health Visiting and Midwifery have access to this information.	N/A
BHR Safeguarding Partners consult with local housing providers about how the learning from this review can inform approaches to address the risks associated with the placing of						

Recommendation	Redbridge SCP	B&D SCP	Havering SCP	East Area BCU MPS	BHR CCGs	BHR Safeguarding Partners
asylum seekers with dependent children in the Borough.						
BHR Safeguarding Partners widely disseminate the learning from this SCR and take that opportunity to remind practitioners about policy and practice in respect of modern slavery.	Redbridge SCP to develop a learning slide pack. Promote the learning slide pack across all agencies working with children, young people and families.	Promote the learning slide pack across all agencies working with children, young people and families.	Promote the learning slide pack across all agencies working with children, young people and families.	N/A	Promote the learning slide pack across all agencies working with children, young people and families.	Learning slide pack in development by RSCP Training Manager. To be published and disseminated when available.

Reply address: RSCP@redbridge.gov.uk

Kevin Foster MP

Minister for Future Borders and Immigration

UK Visas and Immigration

Home Office

2 Marsham Street

LONDON

SW1P 4DF

15 October 2020

Dear Mr Foster

Serious Case Review Recommendation

The former Redbridge Local Safeguarding Children's Board (LSCB) published on 14 January 2020 a report of a Serious Case Review (SCR) concerning the death of 'Baby T', a copy of which is enclosed. 'Baby T' was the child of a Vietnamese asylum seeker. She died at the age of 11 months whilst in the care of an unregistered childminder, who was subsequently convicted of her manslaughter.

The review makes several recommendations to the Home Office which were referred to your Department by the Independent Chair of the Redbridge SCP, John Goldup, in February 2020.

Recommendation 3 (below) was for the statutory safeguarding partners, the Barking & Dagenham, Havering and Redbridge (BHR) Safeguarding Partnership, to seek support with.

> **The BHR Safeguarding Partnership to request that the Home Office consider the recommendation that asylum-seeking mothers and their baby are never moved before the child is eight weeks old or the relevant clinician confirms that essential core postnatal care has been completed, whichever is the longer.**

The background to this recommendation is contained in paragraph 7.5 of the report. The SCR Panel understood that an internal recommendation had already been made in the Home Office to this effect.

I look forward to your response to this recommendation.

Yours sincerely

Adrian Loades

Corporate Director of People, LB Redbridge

On behalf of the BHR Safeguarding Partnership

Reply address: RSCP@redbridge.gov.uk

FAO:

Chair

Executive - London Safeguarding Children Partnership

C/O London Councils

59½ Southwark Street

LONDON SE1 0AL

15 October 2020

Dear Chair

Serious Case Review Recommendation

The former Redbridge Local Safeguarding Children's Board (LSCB) published on 14 January 2020 a report of a Serious Case Review (SCR) concerning the death of 'Baby T', a copy of which is enclosed. 'Baby T' was the child of a Vietnamese asylum seeker. She died at the age of 11 months whilst in the care of an unregistered childminder, who was subsequently convicted of her manslaughter.

One of the recommendations was that the BHR Safeguarding Partnership share this SCR report with the London Safeguarding Children Partnership Executive so that the provision of enhanced training on the complexities of the asylum system to practitioners involved in providing support to asylum seekers and their children can be considered by other London Boroughs.

It would be helpful if you could arrange for the issues raised in the Report to be shared across London Boroughs.

Yours sincerely

Adrian Loades

Corporate Director of People, LB Redbridge

On behalf of the BHR Safeguarding Partnership

Reply address: RSCP@redbridge.gov.uk

FAO:

Sir Simon Stevens

Chief Executive

NHS England,

PO Box 16738,

REDDITCH B97 9PT

15 October 2020

Dear Sir Stevens

Serious Case Review Recommendation

The former Redbridge Local Safeguarding Children's Board (LSCB) published on 14 January 2020 a report of a Serious Case Review (SCR) concerning the death of 'Baby T', a copy of which is enclosed. 'Baby T' was the child of a Vietnamese asylum seeker. She died at the age of 11 months whilst in the care of an unregistered childminder, who was subsequently convicted of her manslaughter.

One of the recommendations (Recommendation 11, page 63) was that the statutory safeguarding partners request that NHS England emphasise the importance of obtaining comprehensive information from pregnant asylum seekers and asylum seekers with infant children to all GP practices in England.

I am writing to seek your support with this recommendation.

Yours sincerely

Adrian Loades

Corporate Director of People, LB Redbridge

On behalf of the BHR Safeguarding Partnership

Reply address: RSCP@redbridge.gov.uk

FAO: Chairs of

City of London & Hackney Safeguarding Children Partnership

Croydon Safeguarding Children Partnership

Cardiff & Vale of Glamorgan Regional Safeguarding Children Board

15 October 2020

Dear Chairs

Serious Case Review Recommendation

The former Redbridge Local Safeguarding Children's Board (LSCB) published on 14 January 2020 a report of a Serious Case Review (SCR) concerning the death of 'Baby T', a copy of which is enclosed.

'Baby T' was the child of a Vietnamese asylum seeker. She died at the age of 11 months whilst in the care of an unregistered childminder, who was subsequently convicted of her manslaughter.

On behalf of the SCR Panel, I would like to thank those agencies in your areas that took part in the Review and would commend the Report to them.

Recommendation 12 (page 64) of the Report was:

> that the BHR Safeguarding Partners share this SCR Report with the Safeguarding Children Partners in the London Boroughs of Hackney and Croydon and in Cardiff so that they can consider the report and advise of any need for improvements in practice which they identify, and the action they propose to take.

I would ask that you disseminate the Report the report and consider the findings and apply any appropriate learning in your areas.

Many thanks.

Yours sincerely

Adrian Loades

Corporate Director of People, LB Redbridge

On behalf of the BHR Safeguarding Partnership

Multi-Agency Safeguarding Partnership

Initiating a Child Safeguarding Practice Review or other Practice/Management Learning options

2020

Other documents making up this Protocol

1. Referral Form for Serious Incidents
2. Rapid Review Process & Timeline
3. Rapid Review Individual Agency Summary
4. Reviews not reaching the criteria for a CSPR
5. Case Review tracker – to be added
6. Child Death Review Process – to be added

1. Introduction

1.1. The Barking, Havering & Redbridge (BHR) Safeguarding Children Partnership is committed to supporting a mutual and reflective learning culture within and across all partners. We want to bring about changes that will lead to an improved practice system for children and families and a reduction in child abuse and neglect.

1.2. Historically our learning and our resources have been focused on safeguarding incidents that required formal statutory reviews. Whilst we will continue to learn from incidents in which children die or are seriously harmed, we will use the new freedom we have as a partnership to capture learning that is proportionate and meaningful rather than who did or did not do what and when.

1.3. Following a referral and consideration by a **Practice Review Group**, or similar multi-agency group we may recommend a review by the national Child Safeguarding Practice Review Panel, commission a local child safeguarding practice review, undertake a local multi or single agency learning review or consider whether a single or multi-agency audit might provide the most useful learning.

1.4. This operational protocol refers to all children and young people who are considered to be resident in the BHR area.

1.5. This protocol is made up of a suite of documents that together makes up the agreed working document for Barking and Dagenham, Havering and Redbridge as part of the Safeguarding Partnership across the BHR footprint.

2. What is a Serious Safeguarding Incident?

2.1. The identification of serious child safeguarding cases will primarily be through the notification requirements placed on the Local Authority which require incidents (set out below) to be notified to the Child Safeguarding Practice Review Panel.

2.2. **Section 16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) and Working Together to Safeguard Children (2018) states:**

Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel (the National Panel) if –

(a) the child dies or is seriously harmed in the local authority's area,

or

(b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England

2.3. If any agency believes that a child has suffered significant harm due to abuse and neglect and meets the criteria for a referral to the Safeguarding Partnership they should make a referral using the Referral-Form-for-serious-incidents as soon as possible after the serious incident occurs.

2.4. In a minority of these cases, these will be child deaths. It is important to recognise that the vast majority of child deaths are the consequence of medical or public health factors and very few relate to safeguarding. Whenever the death of a child is sudden with no apparent cause, a Joint Agency Response (JAR) in the hospital will look at the circumstances surrounding the death. If, after investigation, they have cause to believe that abuse is known or suspected the Chair of the JAR meeting should refer to the Partnership using the referral form.

2.5. All cases that meet the criteria **must** be referred to the National Child Safeguarding Practice Review Panel by the local authority within 5 working days using the online notification process. A copy of the notification will be provided to the Partnership Manager. Any organisation with statutory or official duties in relation to children (including those involved in the Child Death Review process) should inform the Safeguarding Partnership of any incident which they think should be considered for a child safeguarding practice review.

2.6. In addition, Safeguarding Partners at the local level must make arrangements to:

- identify child safeguarding cases which raise issues of importance in relation to the area

and

- commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken

2.7. 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.

- recurrent themes in the safeguarding and promotion of the welfare of children.

- concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children; and

- a case that the Child Safeguarding Practice Review Panel has considered and concluded a local review may be more appropriate.

2.8. 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.

2.9. Safeguarding partners must consider the criteria and guidance set out at paragraphs 2.2 and 2.6 of this document, when determining whether to carry out a local child safeguarding practice review.

2.10. This document describes the process across BHR for discharging these arrangements when deciding to initiate a Child Safeguarding Practice Review or other action.

3. How a Recommendation/Decision will be made

3.1 To ensure that the Strategic Partners are supported to make the key decisions a recommendation will be made to them by the local **Practice Review Group** or similar multi-agency group.

3.2 Chaired by the Local Authority Head of Safeguarding or equivalent senior officer, this group will be made up of senior operational managers from the safeguarding partners who act as decision makers of their organisations. Summary of functions:

- Undertake a 'Rapid Review' of cases in accordance with procedures set out in these arrangements Rapid Review Process
- Make recommendations about whether to undertake a CSPR and agree Rapid Review reports to the Strategic Safeguarding Partners
- Coordinate Learning Reviews

3.3 The MASP Business Manager will be responsible for the process of any papers to enable this discussion and progress to Strategic Partners. All of this will be done on a pro-forma basis and may be done virtually. Records must be kept of every notification and its outcome. Rapid Review Individual Agency Summary

3.4 Where a recommendation/decision is made that the criteria for a Child Safeguarding Practice Review (para 2.2) is met this should be referred to National Panel Child Safeguarding Practice Panel.

3.5 Where that criteria is not met, or ultimately the National Panel conclude that a local review may be more appropriate, this process is set out at section 4.

3. Notification Requirements

3.1 Any agency can inform the Multi-Agency Safeguarding Partnership (MASP) of an incident that they believe should be considered for a Case Review or other Practice Learning. To do so, the local referral form Referral-Form-for-serious-incidents should be completed and sent to the Multi-Agency Safeguarding Partnerships Manager

3.2 Where a looked after child has died this notification applies whether or not abuse is known or suspected. The 3 Safeguarding Partners (Local Authority, Police and CCG) must be notified within **five working days** as must the Secretary of State and Ofsted.

3.3 All notifications described above are to be coordinated through the respective BHR Local Authority.

4. When a Child Safeguarding Practice Review is not required – determining other local action

4.1 It is important that local action is determined using the same rigour as required for national reviews. Various types of local review may be used on a flexible basis according to the circumstances. Reviews not reaching CSPR criteria

4.2 The essential criteria for local action is:

i. Evidence of direct practice learning

ii. Working together or organisational challenges including both process and resource issues

iii. Policy development requirements or unclear or uncertain decision making

4.3 Types of review could include:

- a review or audit of practice conducted in one organisation, done jointly or independently.
- A local based case review approach using an ‘independent’ reviewer.
- A workshop/management review to flush out the key issues and learning using various methods including workshops, events, or summits.

- Links to other types of reviews eg, LeDeR, Serious Incidents, Homicide Review could also be considered.

- A themed policy or practice review where core issues have been identified.

5. Links to CDR

5.1 Whatever approach is considered most appropriate, a recommendation should be made to the Strategic Partners as described in para 2.2. The rationale for any recommendation should be carefully recorded.

5.2 As this approach develops it is crucially important that it is organised in conjunction with the new CDR arrangements, most particularly any learning and review activities that may emanate from the CDR process, namely Joint Agency Response (JAR) and Child Death Review Meeting (CDRM).

5.3 While the most usual referral would come from the Joint Agency Response (JAR) meeting, as the CDR arrangements develop it is important to review the referral mechanism to ensure best fit and consistent decision making.

5.4 It is also possible that themed reviews may be initiated as the Child Death Review' gathers momentum. It would be useful to extend this approach across the BHR/CDR footprint and adapt as required. It is important to ensure consistency across the Strategic Partners' span.

6. Reporting back and MASP involvement

6.1 The progress of all ongoing reviews or decisions about reviews will be reported as part of a tracker report to the local Strategic Partnership, the BHR Strategic Partners and the Independent Scrutineer for each partnership. This is to ensure no situations are lost and all are dealt with in a timely fashion.

7. Resolving disputes

7.1 Ultimately any dispute or concerns about the progress of practice development and learning based on this activity should be reported to the Strategic Partners.

Referral form to Barking & Dagenham, Havering & Redbridge Safeguarding Children Partnership for Consideration of a Case Review

This form should be completed as soon as possible and should convey as much information that is available at the time of completion. If information is unavailable do not delay in making this referral. Additional facts can be collated later.

1. Referrer

Name:	
Agency & Designation	
Email, address, phone number	

FAMILY COMPOSITION & DETAILS OF INCIDENT LEADING TO REFERRAL

2. Child and Family

Name of Child:	
Date of Birth:	
Date of death (if applicable) or serious incident	
Date when incident occurred:	
Home address:	
Ethnic origin:	
Faith/Religion	
Disability:	

Subject to a CP Plan or previously subject to CP Process + dates	**YES/NO**
Is the child Looked After?	
Is the child/young person open to Children's Social Care or Early Help (if so, who is the lead practitioner)?	
Whereabouts at time of critical incident	
Carer at time of critical incident	
Are there any adult safeguarding concerns and have these been shared with ASC?	

Family Composition/Significant Others

Name	Relationship to child	DoB	Address	Legal Status and/or current criminal proceedings	Ethnic Origin

3. Other agencies Involved:

Name	Agency	Contact Details	Reason for Involvement & dates.

Case Background

PLEASE NOTE: The information you provide will be used to help establish whether the case meets the criteria for a Child Safeguarding Practice Review or other type of learning review.

Please outline events and circumstances which has triggered the referral.

Please use the chronology table below to outline any events around the time of the incident. PLEASE NOTE: This should only include key events and DOES NOT need to be a detailed chronology at this stage.	
Date/Time	**Event**

Please add any additional information you think may be relevant and may assist decision-making:

Advice and Submission of this Form
A multi-agency Rapid Review of your referral will be undertaken and you will be informed of the outcome**.**

Please submit completed form to:

Rapid Review Process

Day 1
Commissioning
Upon receipt of a referral to the Partnership Manager, the three local safeguarding partners will be notified of the initiation of the Rapid Review process. The communication will be sent to: -

- Metropolitan Police
- Director for Children's Services
- Safeguarding Nurse – CCG
- Director – CCG
- NELFT
- Education (if of school age)
- Legal

The communication will include timescales / rapid review pro-forma / details of the **Practice Review Group** or equivalent who will coordinate the Rapid Review.
The safeguarding partners must immediately identify a named person to lead on the review within their organisation and advise the Partnership office of their details.
The CCG Designated Nurse will co-ordinate notification to health providers relevant to the case.

Day 6 - 7
Internal reports: submission and circulation
All agency Rapid Review reports **MUST** be returned to the Children's Safeguarding Partnership Manager by close of business on day 6 of the Rapid Review timeline.

Health providers' reports will be collated and returned by the CCG Designated Nurse (or named person above). These reports must have been signed off by senior management.

Day 7 – The Partnership Manager will circulate to all involved parties, who will review and consider prior to the Rapid Review meeting.
All partner organisations will need to deploy their own internal processes for facilitating an effective response in the short timescale allowed.

Day 8
Practice Review Group - Rapid Review Meeting
Attendance will include:

- Representation from the safeguarding partners (LA, Police, CCG)
- Representation from any other key providers as identified by the Rapid Review reports
- Representation from Children's Services and Early Help

Purpose

- Discussion on the findings from the Rapid Review reports returned
- Agreement of what is working well and any areas for concerns
- Agree the completion of the Rapid Review report and any themes for the summary/analysis
- Identify any action already taken or required
- Agree any recommendations

Days 9 – 13
Completion first draft report (days 9 – 11)
Completion and finalisation of the Rapid Review report with focus on the summary and analysis section; and learning points.

Circulation and sign off (day 12)

- By day 12 the Partnership Manager will circulate the draft report to all parties involved
- All responses (comments and requested amendments) must be returned to the Partnership Manager by 9.30am on day 13

Sign off by senior managers (day 13)

- Partnership Manager & Head of Safeguarding, or equivalent senior officer, complete amendments and finalise report and send to Strategic Partners

Day 14
Final report
Strategic Partners agree and sign off final copy.

Day 15
Partnership Manager submits the report to the National Panel
Mailbox.NationalReviewPanel@education.gov.uk

Rapid Review Individual Agency Summary (to be completed by all agencies)

You have been identified as an agency that may have had contact with a child who is the subject of a Rapid Review (see Working Together 2018). Please check your agency's records to see if you have had contact with the child, family members or close associates listed below and complete the Individual Agency Summary form.

Please refer to your own agency's guidance on securing files and ensuring access to them throughout the process of a review.

1.1 Subject(s)						
First Names	**Surname**	**Date of Birth**	**Date of Death (if applicable)**	**Gender**	**Ethnicity**	**Address**

1.2 Family Composition / Significant Others (including non-resident parent / guardian, partners, lodgers, grandparents)			
Name	**Relationship to Child**	**DOB**	**Address**

1.3 Your Details			
Name		**Agency Name & Address**	
Email		**Tel No**	
Signed		**Date**	

1.4 Declaration of Contact	
a) Has your agency had contact with the child or family? **If no, there is no need to continue please submit the form to:**	**Yes / No** (delete as appropriate)
b) As far as you are aware, has the child or family been involved with more than one local authority, police area or clinical commissioning group? **Please provide details:**	**Yes / No** (delete as appropriate)

1.5 Your agency role
Please describe the child / family's involvement with your agency / service over the last <u>12 months</u> Include any historical factors that you consider relevant.

1.6 Reflection on Practice
a) Comment on the risk of significant harm to the child, the actions taken in response to risk and your assessment of whether the response was proportionate giving examples of good practice and / or positive impact.

b) Comment on why things happened the way they did and whether the practice in the case is unusual or reflective of a broader pattern of practice in your agency and/or across the system.
c) Identify the learning for your agency, or the wider system, about the strengths and weaknesses of child protection practice and the effectiveness of multi-agency working in the case.
d) Highlight new or recurrent learning and/or improvements that can be made to better safeguard and promote the welfare of children.

1.7 Immediate Action
a) Are there any immediate actions required to safeguard and promote the welfare of this child or other children? Please specify action taken

Please return the form to:

Learning from No Harm Incidents and Good Practice

RATIONALE
The Barking & Dagenham, Havering and Redbridge Safeguarding Children Partnership recognises that if there is a focus for learning only on serious safeguarding incidents where a child has died or been seriously harmed, we risk limiting or distorting our understanding of whole system functioning.

We know that there are sometimes 'no harm' incidents, concerns about safeguarding challenges, feedback from children and families and evidence of good practice that need to be shared and analysed to improve the way we work.

WHAT SHOULD BE REFERRED
We know that the everyday nature of these occurrences can sometimes make them hard to identify and risk can often be overlooked or unnoticed.
In some cases, something could have gone wrong but it has been prevented. In others, something did go wrong but no serious harm was caused. Occasionally a practitioner may be concerned about how services worked together to ensure a child's welfare or safety.

HOW TO REFER
Practitioners should discuss their concerns with their Designated Safeguarding Lead and complete the Referral-Form-for-serious-incidents and send it to: XX

WHAT HAPPENS NEXT
Upon receipt, the referral will be passed to the Chair of the Practice Review group or similar local multi-agency group and circulated to the group's core membership. The group will have a flexible approach in order to respond to cases as they emerge. This will take the form of virtual meetings involving members according to the needs of a particular case. Recommendations from referrals could include:

- Undertaking a Learning Review of the specific case using an independent reviewer.
- Grouping referrals to identify issues for exploration through a thematic learning review or single or multi-agency audits
- A practitioner review to bring out the key issues and learning in a case using workshops, events, or summits.
- Anonymising for use in training
- Taking to the BHR Safeguarding Partnership for wider learning

- Links to other types of reviews eg, LeDeR, Serious Incidents, Homicide Review could also be considered.

Learning and Improvement

Learning and actions for improvement identified from the review process will be disseminated through the locally agreed partnership group and across the Barking, Havering, & Redbridge Partnership via the BHR Strategic Partners group.

Date [Insert]

Dear Safeguarding Lead

Rapid Review

We have received notification of a serious incident which may meet the criteria for a Child Safeguarding Practice Review (CSPR). We will, therefore, be holding a Rapid Review to consider the case.

To inform the Rapid Review meeting, we need to gather the basic facts about the case and determine the extent of agency involvement with the child and/or any family members. This will help the statutory safeguarding partners decide whether to undertake a formal CSPR and to determine the most appropriate method to identify and cascade learning from this case.

We are initially asking agencies to:

- Clarify whether your organisation had any involvement with the subject child and/or family members.
- If yes, to complete Section 2 of the attached form including details of any involvement with the subject child or family member.

If the child or family is **not known** to your organisation, please confirm this in writing.

We are required to hold the Rapid Review meeting and agree the way forward within timescales outlined in national guidance (within 15 working days). This form should, therefore, be returned to us at the e-mail address included on the form **within five working days**. In this case this will be **[insert submission date].**

If you require any further information please contact [insert contact name and phone number].

Yours sincerely

Add appropriate signature for area

Enc: Individual Agency Summary Form

BHR Safeguarding Partnership Case Review Tracker

Initials	Notification Date to NP	Case Summary/Themes	Lead Authority	Update	Presentation to Local SCP	Published Y/N
Family D	May 2017	Child was transferred from Queens to Royal London Hospital via Blue light with suspected insulin overdose. Review focusses on four siblings under serious harm sustained via Fabricated and Induced illness.	LBBD	Publication of report delayed, due to active Police investigation. Additional information is still being requested from the Family Court by CPS. Police to update once CPS have confirmed.	17 10 2018	N
Baby T	23 03 2018	Baby died from head injury whilst being cared for by unofficial childminder.	LBR	SCR published in January 2020. XX recommendations made, including xx for the BHR Safeguarding Partnership.	15 10 2019	14 01 2020
Child F	Dec 2018	10-month old baby died October 2018.	LBBD	Final Panel meeting held 6/8/19 and following amendments from Panel and LSCB Chair, report was circulated to SCR Panel members for sign off ahead of sending to Strategic Partners. Publication delayed due to ongoing police investigation.	???	N
ZP	18 06 2020	Adolescent suicide	LBR	Rapid Review carried out with recommendation not to undertake CSPR, agreed by local statutory safeguarding partners, and sent to the National Panel 17 07 2020. Response received on 03 08 2020. Agreed. Consider themed review across BHR Safeguarding Partnership at meeting on 09 09 2020.	TBC	N/A

Initials	Notification Date to NP	Case Summary/Themes	Lead Authority	Update	Presentation to Local SCP	Published Y/N
TQ	15/06/2020	11-year-old child died suddenly in June 2020. Cause of death still unknown but child's last recorded weight was almost 18 stone. Long-standing professional concern about emotional impact on child of acrimony between parents. Hypothesis that parental neglect may have contributed to child's excessive weight.	LBH	Rapid Review held on 30 June resulted in recommendation that, although a formal local Child Safeguarding Practice Review (CSPR) was not required, the case warranted some learning at a local level. A learning review meeting was held on 28 June, involving the participants in the original rapid review meeting and resulting in a number of recommendations for system improvements. The learning review meeting also identified a number of mitigating actions already underway, and concluded several lines of enquiry which therefore required no further action. The original recommendation not to undertake a formal local CSPR was formally ratified by Havering's local statutory Safeguarding Partners on 31 July and the completed Rapid Review was submitted to the National Panel the same day.	TBC	N/A

Sector Expert Review of multi agency arrangements for protecting children.

Phase One Report.

Sir Alan Wood CBE

18 June 2020.

Introduction

Despite the coronavirus situation I have managed to gather sufficient opinion, information and help to be able to identify a workplan for phase 2 of this review. I am tentatively planning to resume face to face contacts as from early September. The purpose of these will be to test the hypotheses drawn from phase 1 of the review. The hypotheses are structured in four blocks, I comment on each below. In each block I hope to evidence early promise of good practice and areas where more may need to be done to assist change. We have delayed the sending out of a survey to statutory partners and we will do so in phase 2. I suggest the survey is focused on the four sections identified below.

1. Structural

The new arrangements in the Children and Social Work Act allow a great deal of flexibility in setting out the geographical areas to be covered and the agencies to be involved in planning and delivering a multi-agency approach to protecting children. A small number of areas have agreed to work across geographical and administrative boundaries.

Recently new initiatives and challenges have arisen following increased concern about the safety and protection of children -e.g. serious violence, criminal and sexual exploitation, trafficking. This has led to new central government initiatives and a range of funding pots and the creation of new overarching multi agency partnerships.

Despite some examples of good practice, it is not clear that the new multi-agency arrangements have always been involved in or are working sufficiently closely with these new developments. I have looked at academic thinking on this issue e.g. the RSA's report, Learning Cross Public Sector Innovation (2017) on lessons for leading local cross public sector innovations and the principles identified by the NCB in their report on early adopters.

I propose to look at this issue in discussion with the sector about:

- Multiple area partnerships-cross LA/health/Police;
- Engagement with key relevant agencies-especially schools;
- What role is being played by elected regional Mayors and Police and Crime Commissioners;
- Examining interface with other multi agency arrangements-e.g. Violence Reduction Units; Knife crime, Health and Wellbeing Boards; Adult Safeguarding Boards;
- Discussing the modelling of join up by looking at how cross-central government join up supports implementation of the multi-agency arrangements.

2. Leadership

Leadership is often described as the things that top leaders do! The idea of the three statutory partners is to ensure leadership at the highest level of the three organisations (health, Police and local government) take equal responsibility for the delivery of the new multi-agency arrangements. While the legislation allows the actual statutory partner to delegate their role to a nominated person of senior level, this does not remove from the statutory partner the duties imposed by the Act. I have identified some confusion here and the accountability of the nominated statutory partner to the actual statutory partner is not always evident or acknowledged. I have also seen evidence, for example in Tameside, of how the delegation works effectively and the nominated statutory partners are holding the nominated partners to account-for example by use of an independent scrutineer.

The distinct difference between the strategic leadership role of statutory partners and the practice leadership role of senior staff has been grasped in some areas, it is not evident in others. Leadership has to operate at all levels and is, to one degree or another, required in all posts delivering or arranging services to protect children.

I want to look at this by considering issues such as:

- The issue of accountability and legality of the actual v nominated statutory partners;
- The issues statutory partners focus on in their formal meetings;
- The authority and accountability of the statutory partner and their ability to commit their organisation to the delivery of agreed multi-agency arrangements plans (not just finance);
- Decision making by statutory partners;
- Development and training for senior staff;
- Cross-agency workforce development plans;
- National cross-government guidance for statutory partners;
- The role of Lead members and elected politicians.

3. Impact on practice

I have seen some clear evidence of the impact of the new arrangements on practice, for example the evidence of impact where former inadequate Local Safeguarding Children Boards (LSCBs) have transformed into well supported and focused multi-agency arrangements., an example of this is in Lambeth. I have seen where learning from serious events is focused and transmitted quickly through the new arrangements. I want to look at this in more detail and to identify key principles underpinning good practice. This will include working with Kantar Public on their behavioural insights research, the WWCSC in its search for good multi-agency arrangements practice, the evaluation sub-group of the cross-Whitehall safeguarding reform board, considering reports and other documents such as the recent joint inspectorate thematic inspection of inter-familial child sexual abuse.

I have not been asked to specifically consider the model of local learning from serious events or the role and support provided locally by the national Child Safeguarding Practice Review Panel. However, this issue has been raised by local safeguarding partners and learning is a key issue for multi-agency arrangements locally. I have discussed these issues with some of the groups I have met and if helpful, would be willing to look in a bit more detail at the issue.

Issues I will look for include:

- Examples of the difference between current arrangements and things safeguarding partners feel they could/did not do as an LSCB;
- Views of practitioners;
- Development of support for practice leaders;
- Case studies;
- Improved methods/models of learning for serious events;
- Evidence of listening to the view of children/families;
- Information and data sharing;
- The use of cross-agency performance management plans for continuous improvement and use of data.

4. Independence and scrutiny

A number of imaginative approaches have been developed to ensure independent scrutiny of the new arrangements. There is also evidence of more peer review, for example in Hertfordshire and the eastern region, and challenge of the outcomes of the new multi-agency arrangements. There is also some evidence that suggests there is some "old wine in new bottles" taking place, with little change-for example I was told in one area '*the only thing we have changed is the LSCB has become the LSC Partnership*'. Of course, if an area already had high quality multi-agency arrangements in place it may well be the case that little needed to change, however the suggestion that one word being substituted for another is probably hyperbole but, in some cases, may not be!

In discussion with the sector I will look at evidence on:

- Forms and roles of independent scrutiny, particularly the extent of involvement of an external factor;
- Peer led scrutiny;
- Engagement of politicians, police committees and NHS Boards in scrutinising multi-agency arrangements;
- How the views users and children have been incorporated in the process of scrutiny;
- The overall impact of independent scrutiny on multi-agency arrangements.

National support to the development of multi-agency arrangements

I am clear that the settling in of these new multi-agency arrangements requires time and deeper cross-agency working to promote new ways of thinking, planning, assessing and delivering high quality services. For this to happen, and for it to be successful, I am convinced that more needs to be done by central government departments to support

and foment the further development of improvement in multi-agency working at local level.

Information and data sharing

An example of this is with data and information sharing. Despite several cross-government statements and legislation about the need to improve how health, education and local government share data and information, this is still a problem remarked on in reports by inspectorates, learning reviews, the Office for the Children's Commissioner and by individual statutory partners in local areas. It was disappointing that a recent joint letter to statutory partners encouraging a more effective approach to data sharing was signed only by two ministers. This was commented on at local level with people surprised that all relevant ministers were not signatories. Unless all central government departments working on the multi-agency arrangements speak with a core message - the problem of poor data and information sharing will continue to hold back improvement and learning and will not be able to challenge "silo practice" at local level.

Targeted support

The extent of change implied by the new arrangements is quite extensive. We are expecting each area to review and reconsider its multi-agency arrangements and design new approaches in line with new duties and responsibilities. There has been a level of support for the introduction of the new arrangements in each of the statutory partners-for example the national leads appointed to work with areas on developing their engagement with the new multi-agency arrangements, but these have not been sufficiently extensive in my view.

The support seems very well developed in the Police service, in local government the focus has been on the DCS and in health illness has, despite some sterling effort by individuals, meant changes and gaps in the support. Recruitment to the two vacant posts is underway. It is essential that the strategic nature of this work is a key requirement of candidates. It is not enough to have sector specialist knowledge alone. These two national leads must have experience and understanding of the dynamics of how the entirety of the local health service, or a local authority system operates, how cross agency decisions are taken, how chief officers provide leadership and scrutiny and how stubborn problems can be remedied.

A number of local statutory partners have pointed to what they see as an anomaly in terms of national advice-the existence of the statutory guidance for a DCS and lead member but nothing similar for a statutory partner role, and of course, in local government the statutory partner role is more than the DCS and involves the chief executive and elected politicians. I think there is a clear and unambiguous case for developing statutory guidance for the three statutory safeguarding partners. This is a significant lacuna in our intelligence and knowledge about the way in which the new multi-agency arrangements are being introduced and the objective assessment of the impact they are having on children and families. There is a need for the joint inspectorates to develop a practice improvement focused review on the role of the

statutory partners in promoting improvement in practice, so as to promote best practice and aid improvement where necessary.

Inspection of multi agency arrangements

Inspectorates have not yet been in a position to inspect thematically or otherwise the way in which statutory partners and the new multi-agency arrangements are impacting on the quality of service. The issue is not regularly covered in single inspections of local authority children service, health arrangements for protecting children or inspection of police services. A recent thematic inspection of child abuse in families spoke of the need for closer working relations between the police, local government and health but made no detailed reference to the role of statutory safeguarding partners or independent scrutiny of the new multi-agency safeguarding arrangements. In a similar vein, the latest NHS guidance on training for leadership staff in protecting children makes no specific reference to the statutory partner role. I think this is an important issue to look at further.

I will consider:

- The need to further define accountability and responsibility of the role of statutory partners, by providing national guidance equivalent to that provided for a DCS and lead member;
- The continuation and expansion of the resource for national lead for each statutory agency;
- Joint inspectorate planning re the new arrangements;
- Cross-Whitehall join up in providing advice and guidance on multi-agency arrangements,
- The role of the Ministry of Housing, Communities and Local Government in respect of advice to chief executives and the statutory partner role.

Support for Statutory Partners-the cross-Whitehall safeguarding implementation reform board

There is a pressing issue that needs to be considered now. The cross-Whitehall group sits in a position of leadership of the implementation of the multi agency arrangements reform programme. This leadership should be made explicit. Two changes should be considered. First the group needs to have a clear reporting line to the permanent secretary of each government department involved in the reform programme. Second, the group needs to have a small set of clear deliverables which are designed to support and foment the necessary changes to ensure the effective implementation of the new reforms. Working to the cross-Whitehall group, the national leads can then provide information, advice, guidance and evidence of progress with implementing the reforms within a focused framework of priority objectives.

There is, in my view, a very strong case for the cross-Whitehall safeguarding implementation reform board to build on the current model of national leads for statutory partners by seeking a small pool of funding to establish, for a period of 18-24 months, a nationally coordinated team providing support, advice, guidance and

direction to statutory partners. A resource which can offer training and development, troubleshoot local issues and provide regular and focused advice to central government departments and national agencies.

There is a significant gap in the channels of influence and persuasion available to central government in relation to the statutory partners. There is no central hub of intelligence about who they are, what skills or training needs they have, how they can become a power for promoting change and disseminate national policy, indeed we do not even have a national register/data bank of who the statutory partners are. As a matter of priority, a contact list of local statutory partners should be set up and maintained and be used as a key interface for intelligence and data sharing as well as a conduit for advice and guidance between government departments and local statutory leaders. An empowered group of statutory partners may well have helped significantly in dealing with the impact of coronavirus on children and families nationally. As I say in my first hypothesis the bewildering map of local multi agency arrangements could well be effectively navigated if the role of local statutory partners was better understood and made more use of. If the multi-agency arrangements are to be successful, this support to bedding in change for improvement will be a great help if it can be put in place quickly.

The new arrangements provide for each new multi area arrangement to provide at least a yearly report on their work. The report is to be sent to the What Works for Children Social Care and the National Safeguarding Review Panel. There is no guidance or regulation covering what these two bodies should do with the reports. As it stands there is no clarity as to what either body is planning to do, if anything, on receipt of the reports.. This potentially devalues the principal purpose for production of the reports and without a feedback loop local areas may well set little priority producing it. This is an issue the cross- Whitehall group should consider and provide advice on to local areas. Given the impact of the coronavirus on prioritising critical work with service users, the first report may well be delayed. Information on the first year of operation could be collated via a survey asking a small number of questions about progress on implementation and examples of good practice and any challenges. This survey could then be evaluated and presented to the cross Whitehall group. We are planning a survey as part of phase 2 of the work and this could cover this point

Recommendations and Conclusion

1. A national contact list/register of local statutory partners should be drawn and maintained up as a priority task
2. The two vacant national lead posts should be filled a- matter of urgency. Consideration should be given to appointing a small team of national leads with one coordinator/leader.
3. Legal advice should be shared across government departments on the accountability of statutory partners and the issue of nominating individuals to act in their stead. It is not clear that an agreed, common, understanding exists cross government on this very important role.

4. The role of the cross Whitehall safeguarding group should be strengthened and formalised. In terms of accountability its reporting line should be to the permanent secretaries of government departments and a clear set of objectives set for it work and ensuring a clear focus on supporting local delivery groups and shaping the work of the national lead advisers.
5. The timescale for local areas to provide a yearly plan on the effectiveness of their multi agency arrangements should be considered in light of the coronavirus and arrangements for an extension put in place if requested by an area. Advice on what the cross Whitehall group expects the National Safeguarding Review Panel and the WWCSC to do on receipt of the local multi agency arrangements annual reports.
6. Discussion should be held with the relevant inspectorates to consider the role inspection can play in assessing leadership in the new multi area arrangements in particular the role of the Statutory Partners and independent scrutiny.

I am very positive about what I have seen and heard thus far about the development of multi-agency arrangements. There are encouraging signs of change and improvement and some indication of areas that need attention to focus hearts and minds at local level. I think it is urgent for more work to be done now, cross-Whitehall, to sharpen the national drive and support needed to ensure successful implementation of the new legislation at local level.

I will restart physical meetings with the multi-agency arrangements sector as part of phase 2 in September. Prior to that I will continue to hold discussion with colleagues cross the multi-agency arrangements sector and maintain liaison with the remaining national leads and colleagues of the cross-Whitehall group.

I would be grateful for observations on the suggestion I have made regarding a new national lead arrangement to support and develop statutory partners.

I have identified four blocks to look in depth at aspects of multi-agency arrangements, are these sufficient and do they cover key issues for the cross Whitehall group?

I propose to produce a final draft report by the end of December 2020. Is this in line with your thinking and planning?

Sir Alan Wood CBE
18 06 20

BHR Safeguarding Partnership[1]			
Agenda Forward Plan 2020 - 2021			
Meeting: July 2020 – no meeting held			
Meeting: 3 August 2020			
	Update from Partners on impact and response to COVID-19.	All	Standing agenda item
	Domestic Abuse – Presentation of Responses	All	Documents to be shared post-meeting by LBBD and LBR.
	CAMHS Tier 4 – Response to Self-Harm and Eating Disorders	All	
Meeting: 19 September 2020			
	BHR Safeguarding Partnership Annual Report	All	Annual Report to be provided by the statutory partnership – see Working Together 2018 section 35, page 77 – which is commented on by the Independent Scrutineers.
	Update from Partners on impact and response to COVID-19.	All	Standing agenda item.
	Rapid Review/CSPR Process – for approval	TDV	Comments back to TDV by 14 08 2020.
	Joint working with the Violence Reduction Unit (VRU)	AL	TBC – subject to VRU engagement – C/F to October agenda.
	LAC and Care Leavers Placed Out of Borough	All	C/F to November agenda.
Meeting: 15 October 2020			
	Update from Partners on impact and response to COVID-19.	All	Standing agenda item.
	Case Review Tacker	All	Standing agenda item.
	Themed Review Consideration – Adolescent Suicide	AL/LP	
	Redbridge LSCB SCR Recommendations	AL/LP	
	BHR Case Review Guidance and Documentation	TDV	
	Multi-Agency Audit Plan	All	

[1] Meetings are held approximately every six weeks.

	Joint working with the Violence Reduction Unit (VRU)	AL	TBC – subject to VRU engagement
Meeting: November 2020 [Date TBC]			
	Update from Partners on impact and response to COVID-19.	All	Standing agenda item.
	Case Review Tracker	All	Standing agenda item.
	BHR Case Review Guidance and Documentation	TDV	
	LAC and Care Leavers Placed Out of Borough	All	
Meeting: January 2020 [Date TBC]			
	Update from Partners on impact and response to COVID-19.	All	Standing Agenda item.
	Case Tracker Review	All	Standing Agenda item.
	Outcomes, Feedback and Learning from Rapid Reviews and Child Safeguarding Practice Reviews	All	Six-monthly
Meeting: February 2021 [Date TBC]			
	Update from Partners on impact and response to COVID-19.	All	Standing agenda item.
	Case Review Tacker	All	Standing agenda item.
Meeting: March 2021 [Date TBC]			
	Update from Partners on impact and response to COVID-19.	All	Standing Agenda item.
	Case Review Tacker	All	Standing Agenda item.