BHR Safeguarding Partnership
Learning from No Harm Incidents and Good Practice

Rationale
The BHR Safeguarding Partnership recognises that if there is a focus for learning only on serious safeguarding incidents where a child has died or been seriously harmed, there is risk of limiting or distorting understanding of whole system functioning. Sometimes there are '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 agencies work together.

What should be referred?
It is understood 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 initially discuss their concerns with their Designated Safeguarding Lead and then e-mail basic details to the RedbridgeSCP@redbridge.gov.uk for the attention of the Independent Chair.

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 e.g. LeDeR, Serious Incidents, Domestic Homicide Review could also be considered.

Learning and actions for improvement identified from the review process will be disseminated through the locally and via the BHR Safeguarding Partnership.