Barking & Dagenham One Panel Process Guide

Including guidance and processes for Safeguarding Adult Reviews (SARs), Safeguarding Childrens Practice Reviews (CSPRs) & Domestic Homicide Reviews (DHRs)

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Contents

1. One Panel Referral Process

When a professional believes that the criteria has been met on a case for a Domestic Homicide Review (DHR) or a Safeguarding Adult Review (SAR) the referral form is completed and submitted to the Panel bdonepanel@lbbd.gov.uk

In the case of children, the outcome of the Rapid Review (RR) will be shared (or the original referral if it does not meet criteria for Rapid Review - **see Appendix a).** The referral should be made at the earliest opportunity following identification of a case. All referrals should be agreed and signed off by a Head of Service or equivalent. We would expect that the agency representative for the One Panel would be briefed on their own agency referrals ahead of the meeting so that they are prepared for the discussion.

The Partnership Business Managers will review the referral and go back to the referrer if any further information is required. We ask that those making referrals to the One Panel ensure that all available information is submitted otherwise this may delay the process.

The One Panel will consider the request at the next meeting. At the meeting, the Chair will remind Panel Members of the different criteria for each kind of statutory review (see **Appendices**). The Panel will discuss the referral in relation to the criteria for a review. The Panel, via the Chair, will then make a recommendation to relevant Board.

The Chair may decide that further information is required before the Panel can make a recommendation. In which case, the information will be sought by the Business team, circulated to Panel Members and will be brough back to a future meeting for further discussion, unless a different process is agreed by the Panel.

Each partner agency attending the Panel will have one vote, regardless of the number of individual representatives from the agency present. Where there are disagreements at the Panel regarding the most appropriate action in relation to a case, the Chair will escalate this to the statutory safeguarding partners for their final decision as per section 3.

2. One Panel Decision Making

The following section outlines the decision making and responsibilities of the One Panel. Although three separate areas are outlined, any case considered and reviewed by the One Panel will look at where a case may meet statutory requirements for all three types of review and agree that if they meet more than one which process may take the lead.

Children

Initial Decision making is made outside of the One Panel via the Pre-Serious Incident Notification (SIN) Discussion or SIN stage where there are strict timescales in place. If a SIN is made to the National Panel (more details in **Appendix A)** then a rapid review will be scheduled within 15 days of that SIN. The Rapid Review should include Heads of Service/non Director level representatives. If the decision is reached that the referral does not meet criteria for a Rapid Review, then the information is shared with the One Panel, to consider if there is any learning from the referral and how this may be undertaken. If the decision is made at the Rapid Review that the threshold for a

CSPR is not met, then this will also be shared with the One Panel to consider next steps for learning.

- Methodology options can be utilised to support suitable and proportionate learning (see **Appendix D**).
- The chosen form of review is undertaken and shared with the One Panel for discussion, scrutiny and final comments.
- The Panel will agree how the learning will be shared and where responsibility for actions most appropriately sit.
- Any commissioned Child Safeguarding Practice Reviews (CSPR) will be manged via the individual CSPR Panel formed to oversee the review.
- The final draft of the report will be shared with the One Panel for discussion in response to the findings.
- The CSPR final report will then go to the Safeguarding Childrens Partnership (SCP) for final agreement and sign off and submission to the national CSPR Panel.
- Copies will also be sent to the Department for Education (DfE) and to Ofsted. The final report will be shared with the One Panel.
- Oversight for completion of actions sits with the SCP.

Adults

- The One Panel makes the decision as to whether a referral meets the criteria for a Safeguarding Adult Review (SAR) under the Care Act 2014 S44 utilising **Appendix C** decision making tool,
- If the decision is that the criteria is not met for a SAR, the One Panel can consider if there is any learning from the referral and how this may be disseminated. **Appendix D** methodology options can be utilised to support suitable and proportionate learning.
- The outcome of the decision must be shared with the Safeguarding Adults Board (SAB)
- If a SAR is agreed this will be manged via the SAR Panel.
- The final draft of the report will be shared with the SAB for final agreement and sign off.
- The report will be shared with the One Panel for discussion in response to the findings.
- Oversight for completion of actions sits with the SAB.

Domestic Homicide

- The One Panel makes the decision as to whether a referral meets the criteria for a Domestic Homicide Review (DHR) utilising the domestic homicide decision support information at **Appendix B.**
- If the decision is not to hold a statutory review the One Panel can consider if there is any learning from the referral and how this may be disseminated.
- **Appendix D** methodology options can be utilised to support suitable and proportionate learning.
- The outcome of the decision must be shared with the Community Safety Partnership (CSP) who hold statutory responsibility for DHRs.
- If the threshold for DHR is met it will be commissioned and overseen by the CSP.
- The final draft of the report will be shared with the CSP for final agreement and sign off.
- The report will be shared with the One Panel for discussion in response to the findings.
- Oversight for completion of actions sits with the CSP.

3. Commissioning Reviews

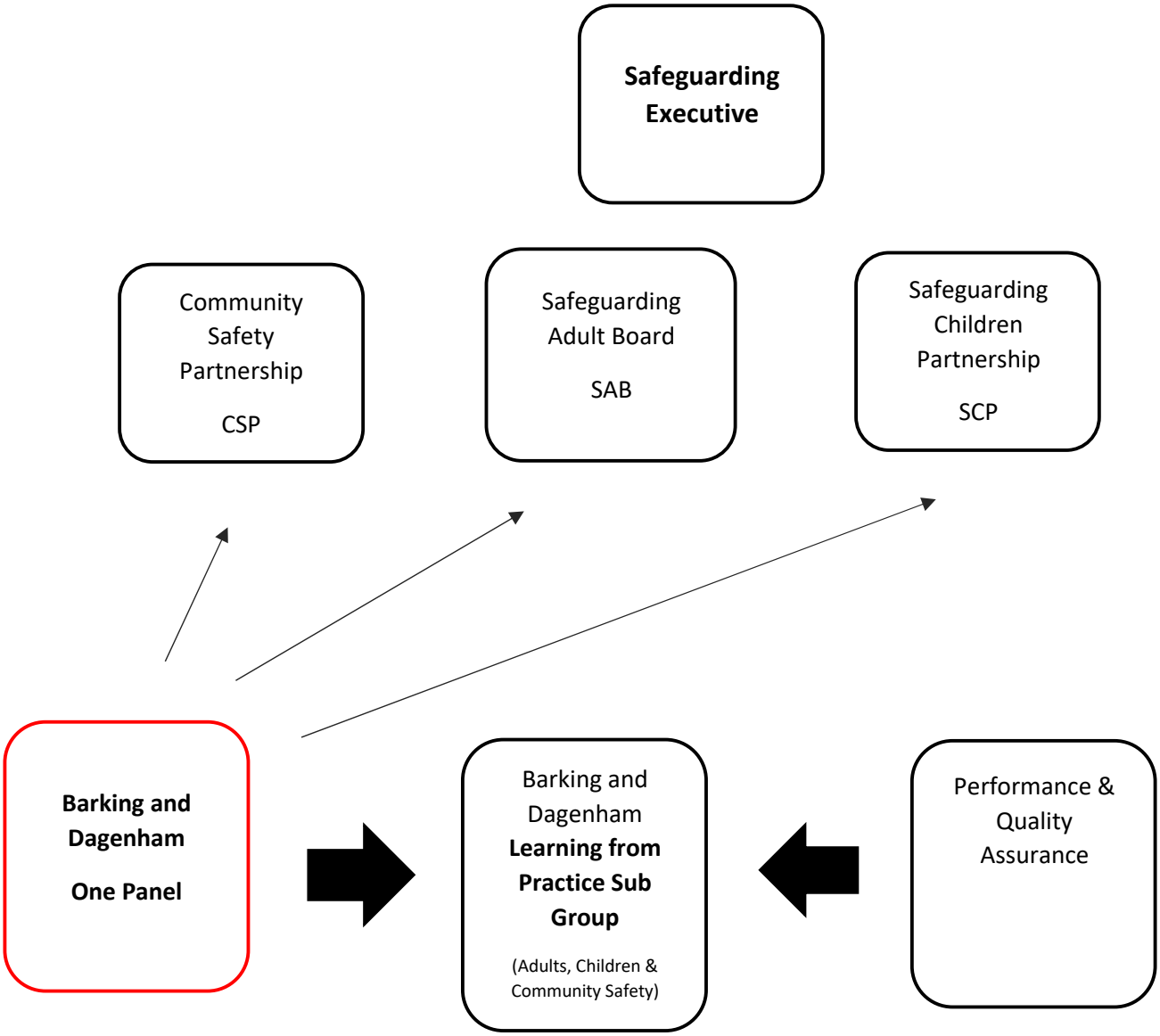
As well as making a recommendation to the statutory safeguarding partners on the type of review, the One Panel can also make recommendations in relation to the focus and methodology. The Barking and Dagenham Safeguarding Adult Board, Safeguarding Children's Partnership and Community Safety Partnership will be responsible for commissioning reviews, including identification of an independent reviewer and managing the review.

4. Support for Staff

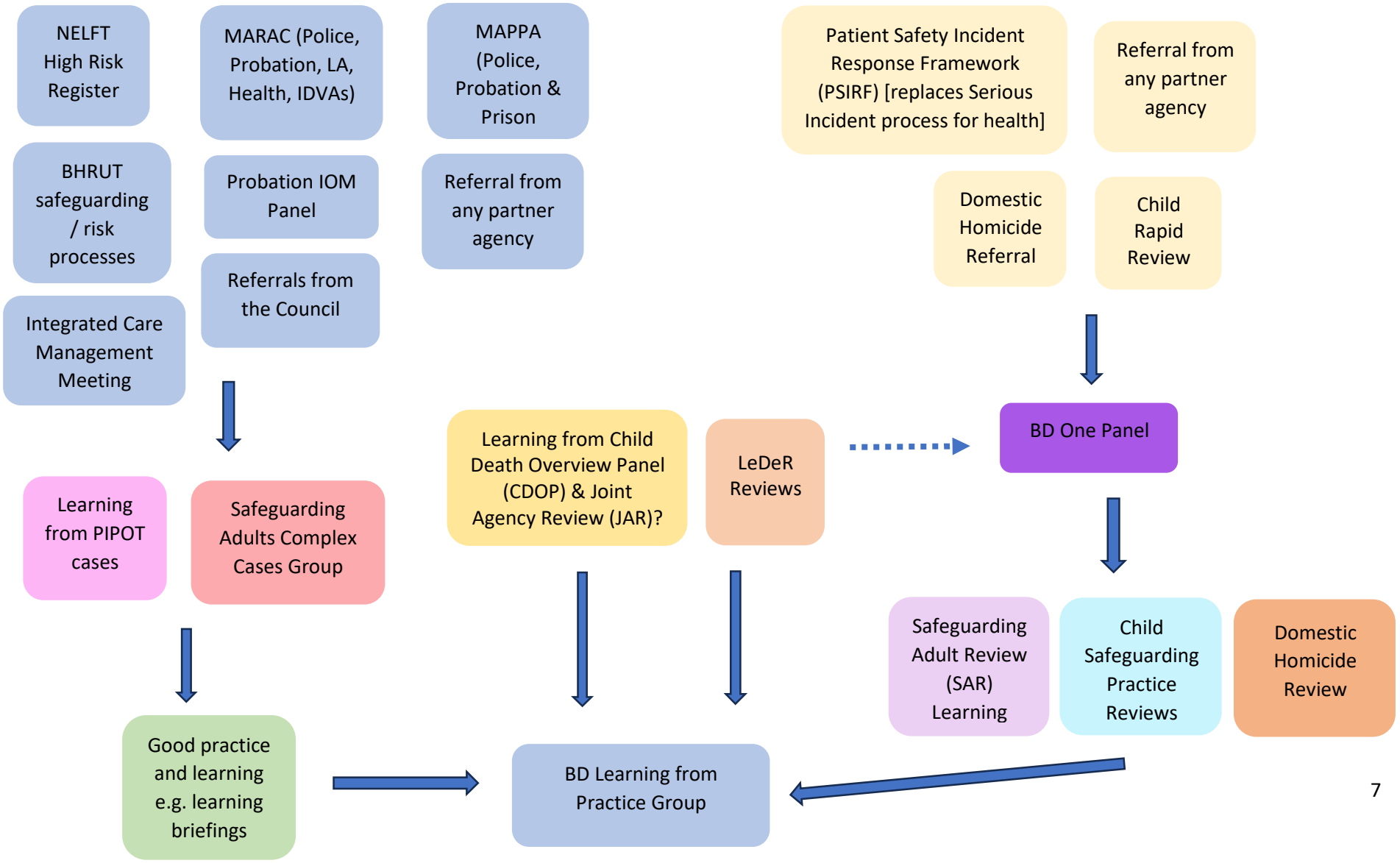
The One Panel recognises that whether referrals/reviews/serious incidents, have resulted in serious harm or death, this can be a very distressing time for practitioners. The Panel is committed to ensuring staff receive the support and guidance they need through all of the processes, statutory or otherwise.

Each agency will have its own policy and process on support for staff wellbeing and we encourage managers to discuss this with their staff and colleagues. Where support is needed for completion of documents or scoping templates then please contact the relevant partnership direct or the bdonepanel@lbbd.gov.uk.

5. Where does One Panel sit within the Partnerships

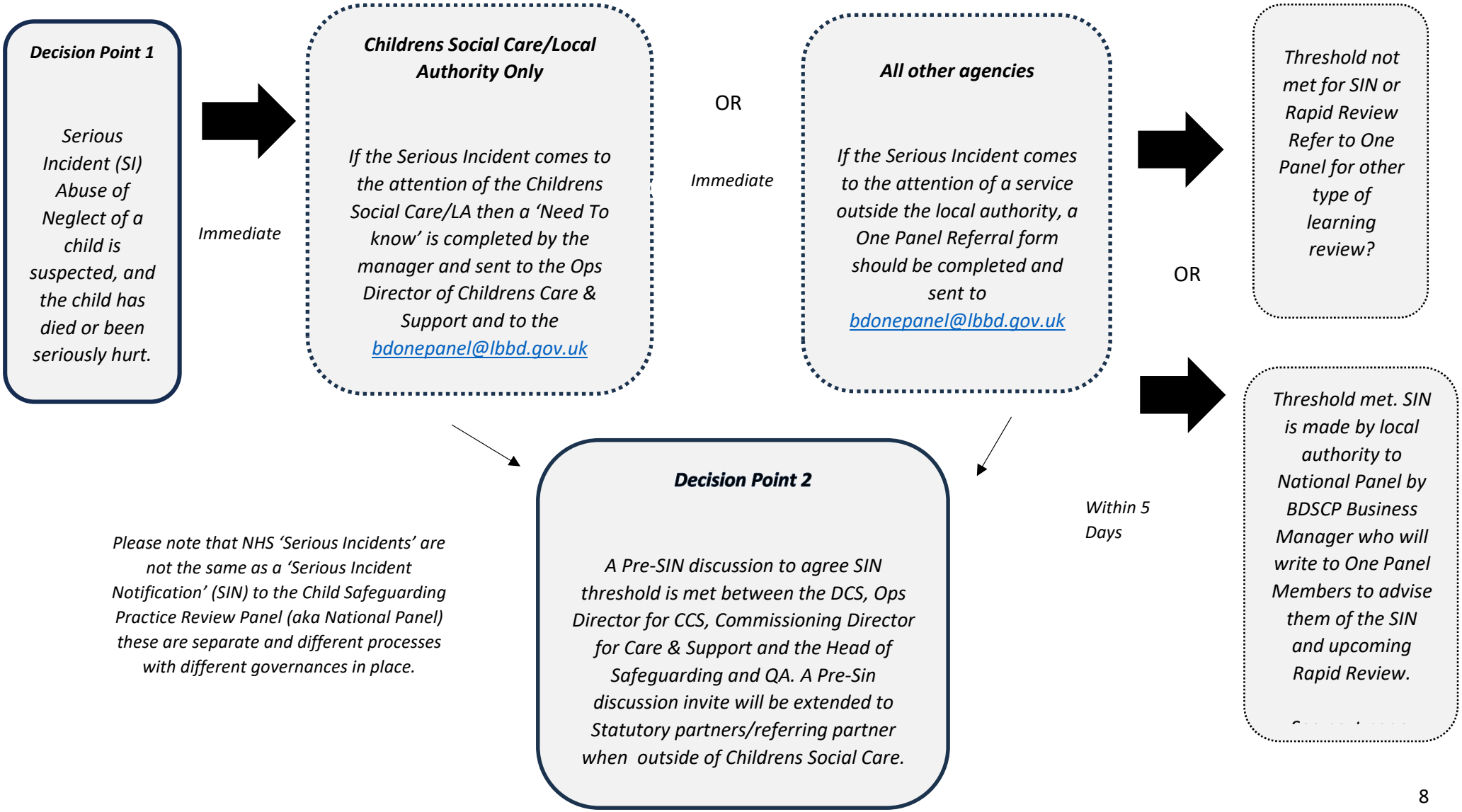


6. Routes to One Panel



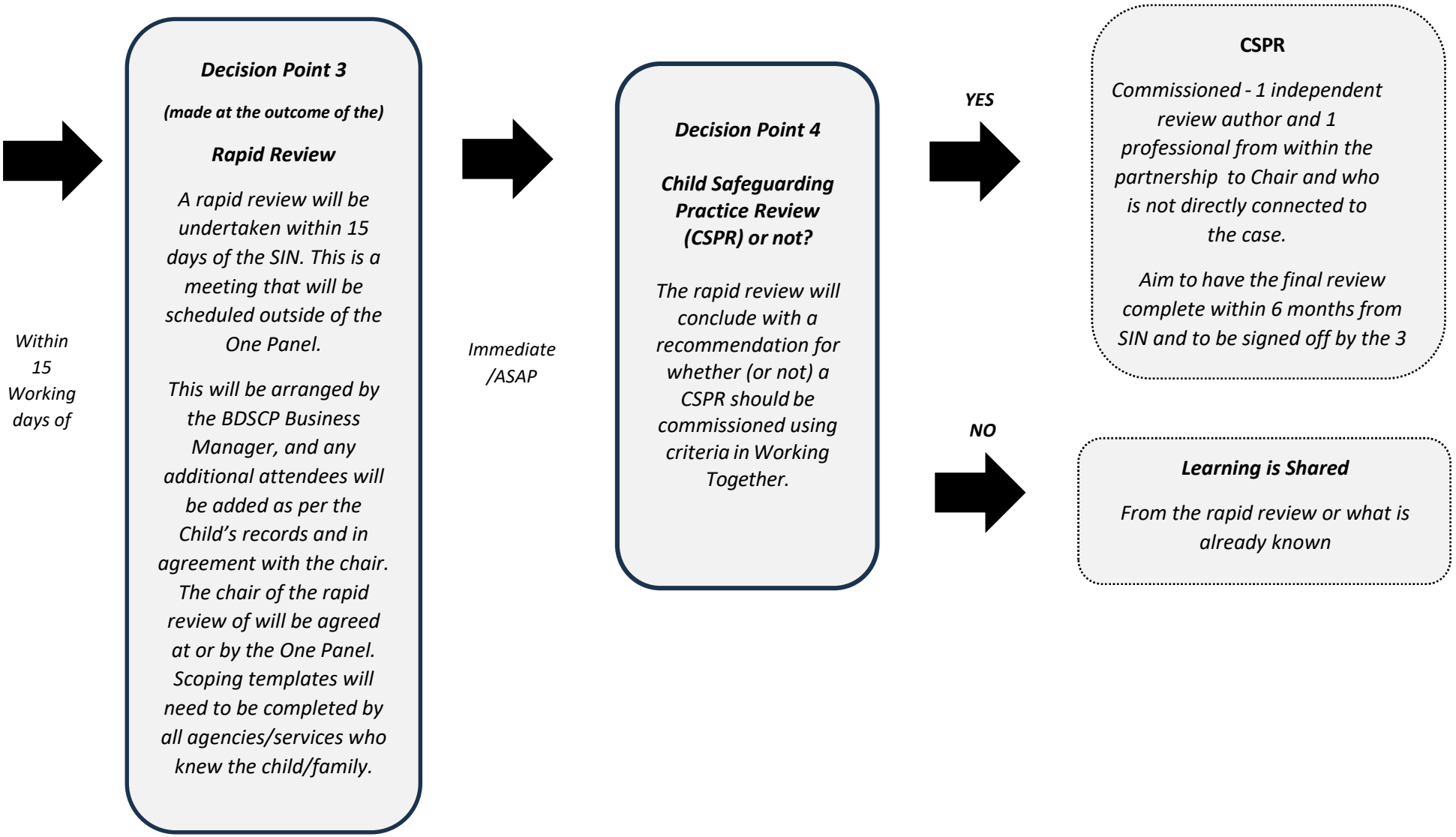
7. Process for Serious Incident Notifications (SIN) & Rapid Reviews

Incorporates/covers statutory process as described in Working Together 2023

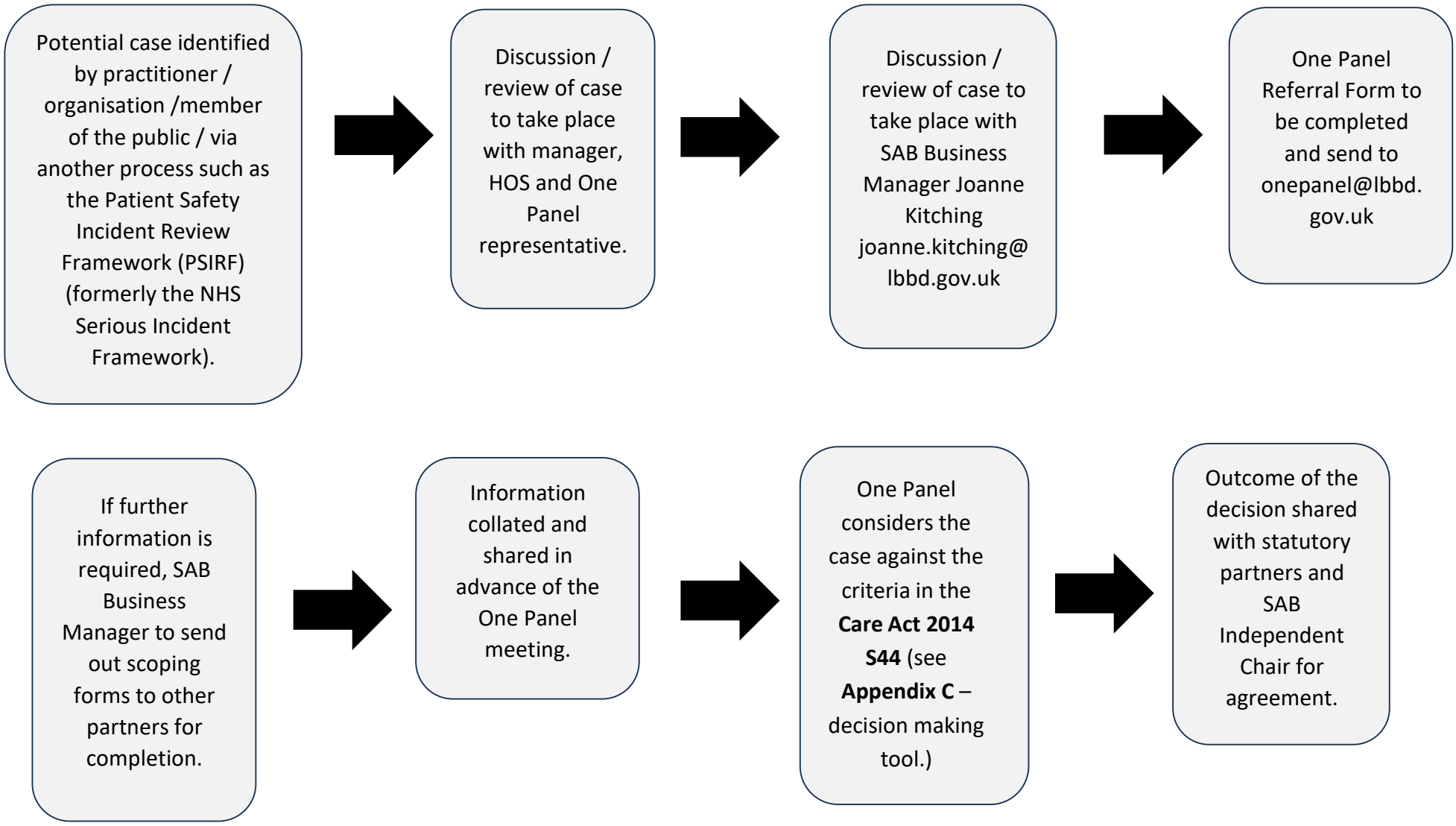


Please note that NHS 'Serious Incidents' are not the same as a 'Serious Incident Notification' (SIN) to the Child Safeguarding Practice Review Panel (aka National Panel) these are separate and different processes with different governances in place.

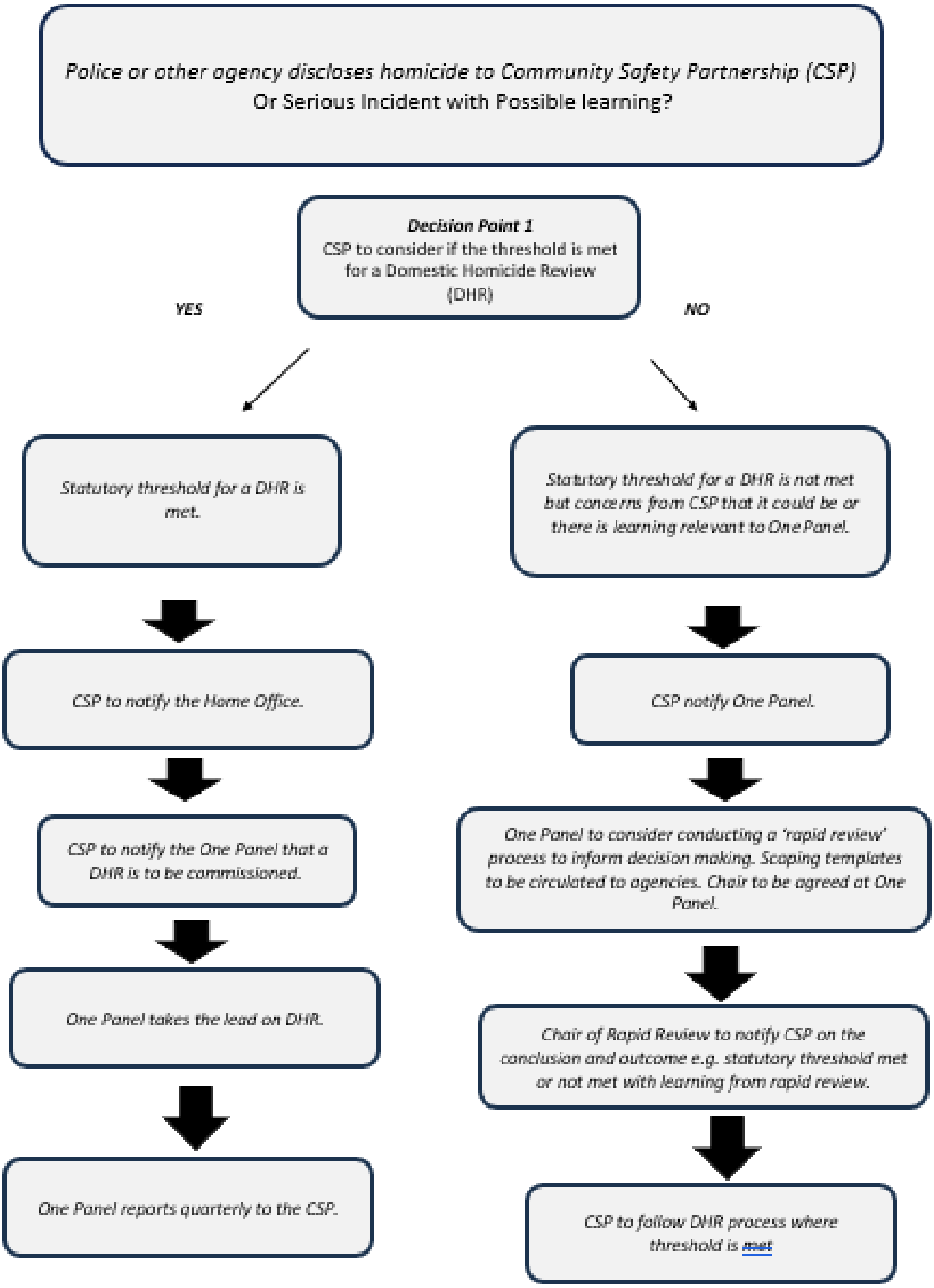
Process continued…



8. One Panel Process for Safeguarding Adult Reviews (SARs)



9. One Panel Process for Domestic Homicide Reviews (DHRs)



Appendix A

Children Rapid Reviews Supporting Information

Working Together 2023, Chapter 5

Decisions on local and national reviews

336. Safeguarding partners must:

• identify serious child safeguarding cases that raise issues of importance in relation to their area
• commission and oversee the review of those cases if they consider review appropriate

337. When a serious incident becomes known to safeguarding partners, they must consider whether the case meets the criteria and guidance for a local review. If safeguarding partners determine that the criteria is met to undertake a local child safeguarding practice review, then a serious incident notification and rapid review must take place.

338. **In some cases, a 'serious child safeguarding case' may not meet the criteria for a serious incident notification but may nevertheless raise issues of importance to the local area. That might, for example, include where there has been good practice, poor practice or where there have been 'near-miss' incidents. Safeguarding partners may choose to undertake a local child safeguarding practice review in these or other circumstances, in Report a serious child safeguarding incident. This means any person or organisation with statutory or official duties or responsibilities relating to children, Children Act 2004 Section 16F 135 which case they should be clear about their rationale for undertaking such a review and what its focus will be.**

339. It is for safeguarding partners to determine whether a review is appropriate, given that the purpose of a review is to identify improvements to practice. Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review.

340. All incidents should be considered on a case-by-case basis using all information that is available to local safeguarding arrangements. Issues might appear to be the same in some cases, but reasons for actions and behaviours may differ resulting in useful learning for the local area.

341. Decisions on whether to undertake reviews should be made transparently and collaboratively between safeguarding partners, and the rationale recorded and communicated appropriately, including to families. Where there are disagreements, local dispute resolution processes should be followed.

Learning from local reviews should be reflected in the annual reports published yearly by the safeguarding partners. The criteria safeguarding partners must take into account include whether the case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children.
- is one the panel has considered and has concluded a local review may be more appropriate:
- The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018
- Safeguarding partners should also have regard to circumstances where:
- they have cause for concern about the actions of a single agency.
- there has been no agency involvement, and this gives them cause for concern.
- more than one local authority, police area or ICB is involved, including in cases where a family has moved around.
- the case may raise issues related to safeguarding or promoting the welfare of children in institutional settings.

The safeguarding partners should promptly undertake a rapid review of the case, in line with any guidance published by the panel. The aim of this review is to enable them to:

- gather the facts about the case, as far as they can be readily established.
- discuss whether any immediate action is needed to ensure children's safety and share any learning appropriately.
- consider the potential for identifying improvements to safeguard and promote the welfare of children.
- decide what steps they should take next, including whether to undertake a child safeguarding practice review.

As soon as the rapid review is complete, the safeguarding partners should send a copy of their findings to the panel. They should also share with the panel their decision about whether a local child safeguarding practice review is appropriate, or whether they think the case may raise issues that are complex or of national importance such that a national review may be appropriate. They may also do this if, during a local child safeguarding practice review, new information comes to light suggesting that a national review may be appropriate. As soon as they have determined that a local review will be carried out, they should inform the panel, Ofsted and DfE, providing the name of the reviewer they have commissioned.

Arranging a Rapid Review in Barking and Dagenham and relation to the One Panel

See appendix A One Panel process for serious incident notifications and rapid reviews on Page 10 of this guidance.

A rapid review will be undertaken within 15 days of the SIN. This is a meeting that will be scheduled outside of the One Panel.

This will be arranged by the BDSCP Business Manager, and any additional attendees will be added as per the Child's records and in agreement with the chair. The chair of the rapid review of will be agreed at or by the One Panel. Scoping templates will need to be completed by all agencies/services who knew the child/family.

Child Death Reviews

Child Death Review (CDR) is the process to be followed when responding to, investigating, and reviewing the death of any child under the age of 18, from any cause. It runs from the moment of a child's death to the completion of the review by the Child Death Overview Panel (CDOP). The process is designed to capture the expertise and thoughts of all individuals who have interacted with the case to identify changes that could save the lives of children.

The local arrangements for implementing the Child Death Review (CDR) system have been agreed across Barking and Dagenham, Havering and Redbridge and can be found here:

Barking and Dagenham, Havering and Redbridge Child Death Review (PDF, 1.52 MB)

In accordance with the statutory guidance Working Together to Safeguard Children 2023 Child death review partners must make arrangements for the analysis of information from all deaths reviewed. The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If child death review partners find action should be taken by a person or organisation, they must inform them.

Statutory guidance for all multi-agency professionals (PDF, 1.3 MB)

Notification of a Child Death

The notification of a child death should be undertaken via completion of Form A on the eCDOP System within 24 hours using the link below:

BHR eCDOP System

Child Death Review Meeting (CDRM)

This is a multi-professional meeting where all matters relating to an individual child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death.

Child Death Overview Panel (CDOP)

BHR Child Death Overview Panel (CDOP) is now part of this tri-borough arrangement. The aims of the panel are to: Learn from the deaths of children to help identify ways of preventing future deaths. Identify any improvements that can be made in the services provided to children and their families. Improve the experience of bereaved families and support professionals to care for families effectively. It is a multi-agency panel, set up by the CDOP Manager for BHR (NHS) and attended by the CDR Partners who are senior professionals who would not have provided care for the child during their lifetime which ensures independent scrutiny.

Joint Agency Reviews (JAR)

JAR is a coordinated multi-agency response by the named nurse, police investigator, duty social worker and should be triggered if a child dies:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy/childhood (SUDI/C);
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural; or
- in the case of a stillbirth where no healthcare professional was in attendance.

All deceased children that meet the criteria for a JAR should be transferred to the nearest appropriate Emergency Department (ED) to enable the JAR to be triggered. A JAR should also be triggered if such children are brought to hospital near death, are successfully resuscitated, but are expected to die in the following days. In such circumstances the JAR should be considered at the point of presentation and not at the moment of death, since this enables an accurate history of events to be taken and, if necessary, a 'scene of collapse' visit to occur.

The "Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation (2016)" gives comprehensive advice and expectations of all agencies involved in a JAR, and should be applied in full by all agencies. Effective cross-agency working is key to the investigation of such deaths and to supporting the family. It requires all professionals to keep each other informed, to share relevant information between themselves, and to work collaboratively.

Appendix B

Domestic Homicide Decision Supporting Information

DHR Statutory Guidance

Domestic Homicide Reviews (DHRs) were introduced in the Domestic Violence, Crime and Victims Act 2004, and came into force in April 2011. A DHR is a process of investigation, re-evaluation, analysing, scrutinising, and making recommendations, by reviewing the circumstances surrounding the **death of a person aged 16 or over which has, or appears to have, resulted from violence, abuse, or neglect by:**

• a person to whom she/he was related or with whom she/he was or had been in an intimate personal relationship, or

• a member of the same household as her/himself, held with a view to identifying the lessons to be learnt from the death.

An 'intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of sex, gender identity or sexual orientation.

A DHR should also be conducted where **the death occurred due to the victim taking their own life (suicide) and the circumstances surrounding the death give rise to concern, such as, where it emerges that there was coercive controlling behaviour in the relationship.**

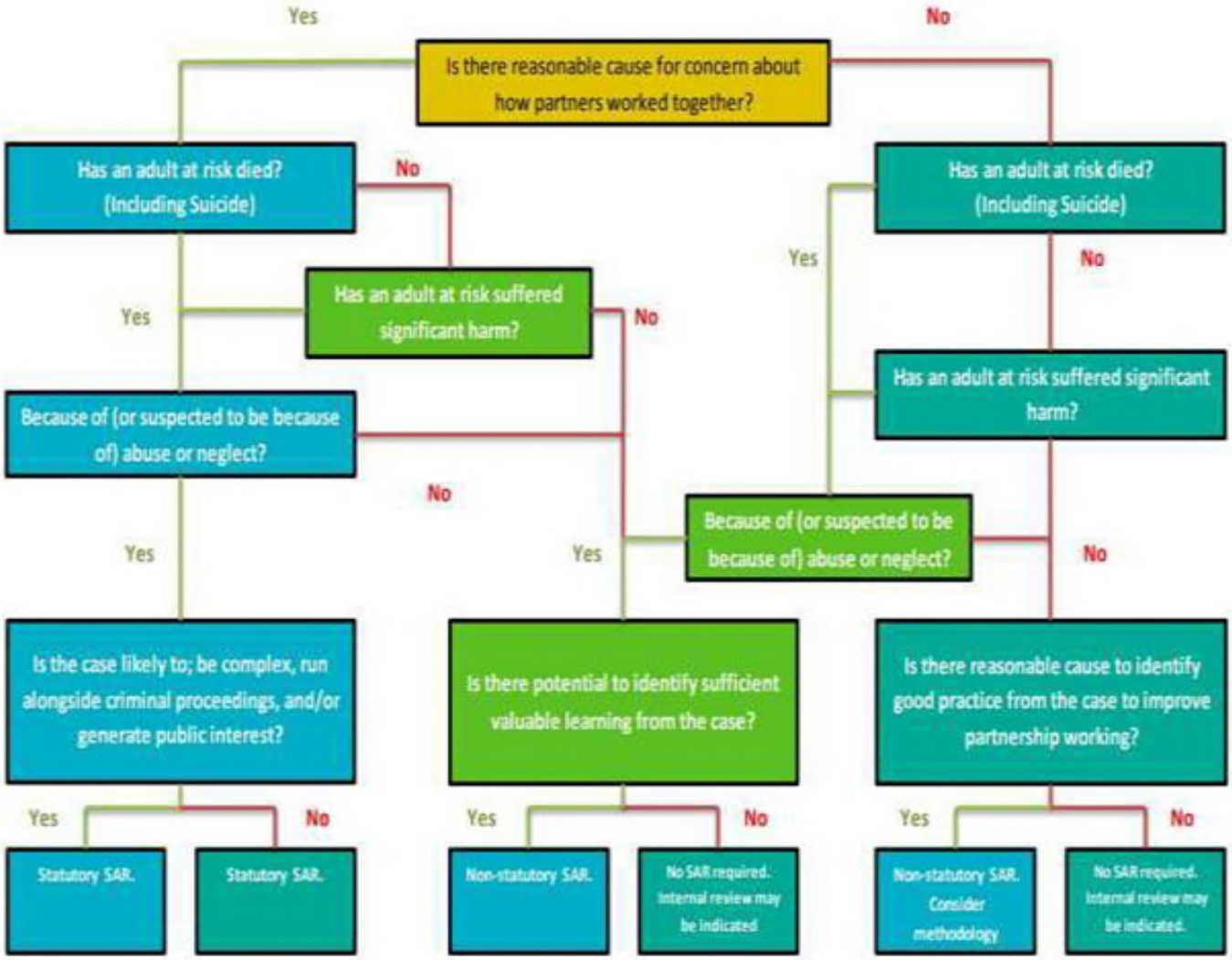
A review should be undertaken, even where a suspect is not charged with a criminal offence, or where they are charged and later acquitted. Where an agency suspects a suicide meets the criteria then they should follow the normal referral process, outlined below. When the definition above has been satisfied, then a DHR should be undertaken.

The Home Office has provided Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, December 2016.

Appendix C

Decision Making Tool for Safeguarding Adult Reviews (SAR)

Care Act 2014 (legislation.gov.uk)



Appendix D
Review Methodology Options

Appreciative Inquiry (AI) Case reviews conducted as an appreciative inquiry seek to create a safe, respectful, and comfortable environment in which people look together at the interventions that have successfully safeguarded a child; and share honestly about the things they got wrong and/or did not have the desired outcome. It is an opportunity to look at where, how, and why events took place and use their collective hindsight wisdom to design practice improvements. To undertake a case review using the AI principles, the facilitator should be familiar with AI and confident in putting this into practice. AI is facilitated through the use of strength based, solution focused language. AI can be used within any methodology of case review.	**Benefits of this model are:** • Keeps the child at the centre. • Promotes reflective discussion and enhances critical thinking and analysis. • Enhances the use of structure professional judgement. • It's all about relationships - making a difference through a strengths-based approach. • Encourages professional curiosity. • Embraces and facilitates a learning culture. • Aims to progress timely and meaningful outcomes for children and families. **Drawbacks of this model are:** • Potential to ignores or even deny problems. • May lead to over optimistic outcomes. • Potential to not intuitively dig deep enough
Reflective Learning Session or multi-agency practitioner events Where an independent review is not required, information is gathered from agencies to contribute to a reflective learning session, attended by the relevant professionals to critically appraise the case and learning recommendations agreed.	**Benefits of this model are:** • Wide range of professionals involved, including those involved in the case and those not involved in the case. • Proportionate and timely • Allows the referrer to be actively involved in discussion. **Drawbacks of this model are:** • Relies on having a robust amount of information prior to, or during discussion to enable the right conclusions to be drawn. • Requires a strong facilitator.

Utilise the Rapid Review approach. This is a methodology suitable for use in a number of types of review. It is based on bringing together elements of effective methodologies such as Situational analysis, Signs of Safety, and Kolb's reflective learning cycle. This model could be used at multi-agency practitioner events, reflective sessions, or rapid and case reviews. The tool provides a structure for practice discussions about individual cases once initial facts are known, for example for a rapid review meeting, practice review discussions or reflective sessions. The purpose of the tool is to guide discussion about specific cases or themes through five stages in a strengths-based way to get from the facts, initial thoughts, and feelings, generating hypotheses and a simple root cause analysis to what needs to happen next in a structured way. It can be used with groups of professionals, or service users.	**Benefits of this model are:** • Simple to use. • Brings together elements of effective methodologies. • Can be undertaken in a short space of time. • Allows for a balanced focus on what works well and what has not worked well. • Child at the centre • Allows systemic factors to be considered. • Reflects on the whole system approach to keeping the child safe. **Drawbacks of this model are:** • New and therefore not yet evaluated as a methodology • Requires participants to display professional curiosity and not be afraid to contribute and challenge. • Requires a strong facilitator
Individual Agency Review This model would be relevant when a serious incident identifies single agency involvement or where potential one agency learning has been identified. There are no implications or concerns regarding involvement of other agencies, and it is appropriate that lessons are learnt regarding the conduct of an agency.	**The benefits of this model are:** • Provides an opportunity for learning from an individual agency. • Enables individual agency scrutiny into a specific area. • Assists a 'Duty of Candour'. • Supports the sharing of learning to further strengthen a whole system approach to safeguarding. **The drawbacks of this model are:** • Can be seen as outside of the purpose of multi-agency learning. • Requires individual agency full buy in and ownership. Risks individual agency opposition.

Multi-agency audits Multi-agency audits of case files that relate to a specific theme is an effective mechanism of understanding practice at child level and practitioners and their managers are involved in identifying what they are doing well and where improvements need to be made. A rolling programme of multi-agency audit themes is identified through local priorities, local reviews, inspection findings, performance data and national research.	**Benefits of this model are:** • Proportionate • Can utilise multi agency auditors. • General thematic learning which can be consider system wide. **Drawbacks of this model are:** • Conclusions from the view point of one or two auditors rather than wholly multi-agency.
Peer review approach A peer review approach encompasses a review by one or more people who know the area of business and accords with self- regulation and sector led improvement programme. Peer review methods are used to maintain standards of quality, improve performance, and provide credibility. They provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice. There are two main models for peer review: • Peers can be identified from constituent professionals/agencies. • Or peers could be sourced from another area which could be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice.	**The benefits of this model are:** • Increased learning and ownership if peers are from the members. • Objective, independent perspective. • Can be part of reciprocal arrangements across/between partnerships. • Cost effective. **The drawbacks of this model are:** • Capacity issues within partner agencies may restrict availability and responsiveness. • Skills and experience issues if reviews are infrequent. • Potential to perceive peer reviews from members of the partnership as not sufficiently independent, especially when they concern political or high-profile cases.

Root Cause Analysis (RCA)

Root Cause Analysis (RCA) is an investigation methodology used to understand why an incident has occurred. RCA provides a way of looking at incidents to understand the causes of why things go wrong. If the contributory factors and causal factors - the root causes - of an incident or outcome are understood, corrective measures can be put in place.

By directing corrective measures at the root cause of a problem (and not just at the symptom of the problem) it is believed that the likelihood of the problem reoccurring will be reduced. This approach can help to prevent unwanted incidents and outcomes, and also improve the quality and safety of services that are provided. The RCA investigation process can help an organisation, or organisations, to develop and open culture where staff can feel supported to report mistakes and problems in the knowledge this will lead to positive change, not blame.

General principles of Root Cause Analysis:

- RCA is based on the belief that problems are best solved by attempting to correct or eliminate root causes.
- To be effective, RCA must be performed systematically, with conclusions and causes backed up by evidence.
- There is usually more than one potential root cause of a problem.
- To be effective, the root cause analysis & investigation must establish ALL causal relationships between the root cause(s) and the incident, not just the obvious.

The benefits of this model are:

- The methodology is well known and frequently used in the NHS.
- Focus is on the root cause and not on apportioning blame or fault.
- Effective for single agency issues especially those related to NHS services.

The drawbacks of this model are:

- Requires skills and knowledge of RCA tools.
- Resource intensive