Learning Inquiry Group

Procedure and Guidance

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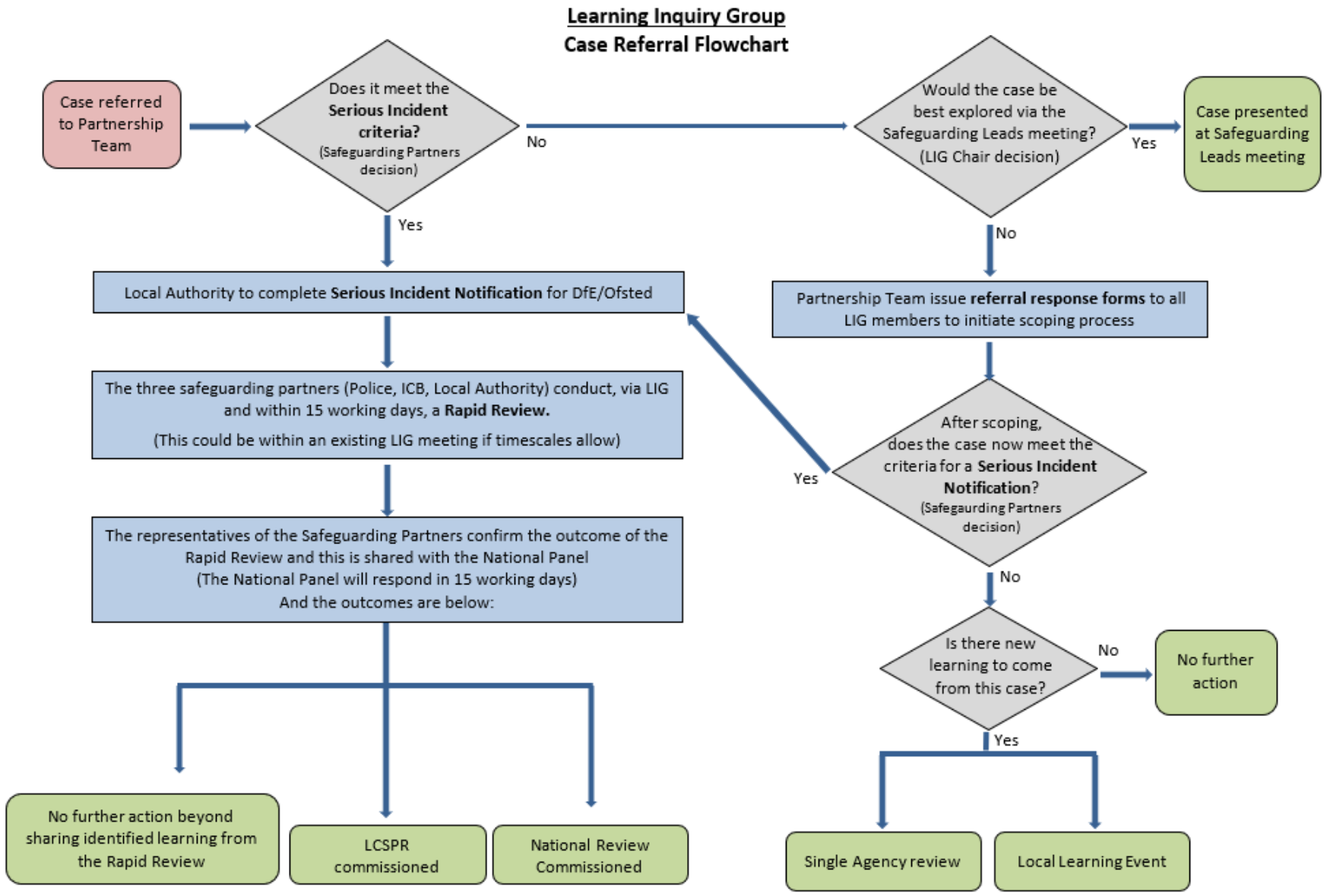
Learning Inquiry Group
Case Referral Flowchart
Case referred to Partnership Team
Does it meet the Serious Incident criteria? (Safeguarding Partners decision)
No
Would the case be best explored via the Safeguarding Leads meeting? (LIG Chair decision)
Yes
Case presented at Safeguarding Leads meeting
Yes
No
Local Authority to complete Serious Incident Notification for DfE/Ofsted
Partnership Team issue referral response forms to all LIG members to initiate scoping process
The three safeguarding partners (Police, ICB, Local Authority) conduct, via LIG and within 15 working days, a Rapid Review.
(This could be within an existing LIG meeting if timescales allow)
After scoping, does the case now meet the criteria for a Serious Incident Notification? (Safegaurding Partners decision)
Yes
No
The representatives of the Safeguarding Partners confirm the outcome of the Rapid Review and this is shared with the National Panel
(The National Panel will respond in 15 working days)
And the outcomes are below:
Is there new learning to come from this case?
No
No further action
Yes
No further action beyond sharing identified learning from the Rapid Review
LCSPR commissioned
National Review Commissioned
Single Agency review
Local Learning Event

Criteria for A Serious Incident Notification

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 if:

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

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

Safeguarding Partners will also have due regard for the additional guidance provided by the Child Safeguarding Practice Review Panel regarding criteria for serious incident notifications.

Responsibility For Decision-Making Regarding Serious Incident Notifications

Though the responsibility to notify rests on the local authority, it is for all three safeguarding partners to agree which incidents should be notified in their local area.

Isle of Wight Council Children's Services – Service Director, Children's Social Care. *In their absence this decision will be made by the Children's Services Department Representative in the Learning Inquiry Group.*

Hampshire and Isle of Wight Constabulary – The Hampshire and Isle of Wight Constabulary Representative in the Learning and Inquiry Group. *In their absence, communication will be shared by the IOWSCP Partnership Team with the generic inbox for the Serious Case Review Team.*

Hampshire and Isle of Wight Integrated Care Board –Designated Nurse for Safeguarding Children. *In their absence, communication will be shared by the IOWSCP Partnership Team with the Designated Doctor For Safeguarding Children and the generic inbox for the ICB Safeguarding Team.*

Decisions on Local Child Safeguarding Practice Reviews

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.

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.

Introduction

The 'Working Together to Safeguard Children' statutory guidance states that: "Child protection in England is a complex multi-agency system with many different organisations and individuals playing their part. Reflecting on how well that system is working is critical in improving our response to children and their families.

Sometimes a child suffers a serious injury or death as a result of child abuse or neglect. Understanding not only what happened but also why it happened can help to improve our response in the future."[1]

The Child Safeguarding Practice Review Panel highlight in the 'Child Safeguarding Practice Review Panel Guidance for Safeguarding Partners' (2022) that: "Children and families involved in the child safeguarding system, as well as the public, rightly expect there to be reflection and improvement when things go wrong to minimise the risk of such tragedies occurring again. It is our collective responsibility to make sure this happens and is done well."[2]

The Isle of Wight Safeguarding Children Partnership (IOWSCP) is resolute in its commitment to fostering a culture of reflective practice, learning and continuous improvement that enable safeguarding partners to:

- Identify and share concerns regarding the safety and welfare of children,
- Highlight commonly recurring themes that require further investigation,
- Share learning from across the safeguarding system, including from success.

The procedures and guidance included in this document supports the work of the Isle of Wight Safeguarding Children Partnership in achieving the following:

- Ensuring that local child safeguarding practice reviews (LCSPRs) are conducted in line with statutory requirements.
- Ensuring local learning happens where the criteria for a local child safeguarding practice review are not met and there remains a need to explore the way agencies are working together to safeguard and protect the welfare of the child.
- Ensuring that learning and recommendations arising from local child safeguarding practice reviews and local learning events result in improvements to the multi-agency safeguarding system.

The Learning Inquiry Group

The Learning Inquiry Group (LIG) is a standing subgroup of the Isle of Wight Safeguarding Children Partnership. The purpose of the Learning Inquiry Group is to ensure multi-agency learning to improve practice in relation to safeguarding children.

The subgroup members have several functions and tasks delegated to them as part of the arrangements made locally by safeguarding partners. [3]

[1] HM Government, Working Together to Safeguarding Children.
[2] Child Safeguarding Practice Review Panel (2022), Child Safeguarding Practice Review Panel Guidance for Safeguarding Partners.
[3] Section 16K of the Children Act 2004, as amended by the Children and Social Work Act 2017, states that the safeguarding partners and relevant agencies for a local authority area in England must have regard to any guidance given by the Secretary of State in connection with their functions under sections 16E-16J of the Act. The Isle of Wight Safeguarding Children Partnership website has information on the arrangements set out for how safeguarding partners and relevant agencies work together across the Isle of Wight to safeguard and protect the welfare of children.

These functions and tasks include the identification and review of serious child safeguarding cases which may raise issues of importance for the local area. In summary, the Learning Inquiry Group members will coordinate the following inter-related activity:

- For safeguarding partners, the consideration of whether the criteria for notification of a serious safeguarding case have been met (serious incident notification).
- Undertake rapid reviews where a serious incident notification has been made and a rapid review is required.
- Making recommendations to the safeguarding partners as to:
  - whether a local child safeguarding practice review should be carried out and the method to be used, or
  - whether the Isle of Wight Safeguarding Children Partnership should take any further action such as convening a multi-agency local learning event or a positive learning review.
- Commissioning local child safeguarding practice reviews and monitor and assure the progress of any such review.
- Commission local learning events or other activity, where agreed, and monitor and assure the progress of commissioned activity.
- Providing scrutiny of partner agencies and the collective Isle of Wight Safeguarding Children Partnership's action plans following the publication of local child safeguarding practice reviews or completion of a local learning event.
- Using the learning from local and national child safeguarding practice reviews[4] to inform policy, practice and the Isle of Wight Safeguarding Children Partnership learning and development programme.

Section A

Referrals to the Learning Inquiry Group for Consideration

Each agency must have arrangements for identifying cases that may be considered a 'serious safeguarding case'. It is important that any practitioner or professional can discuss with their agency Learning Inquiry Group representative any case which they believe may meet the criteria of a serious safeguarding case.

The local Child Death Overview Panel (CDOP) may also make referrals to the Learning Inquiry Group for consideration. The chair of CDOP may refer a case to the Learning Inquiry Group that they consider is likely to have important lessons for inter-agency working and may meet the criteria for consideration as a serious safeguarding case.

The Learning Inquiry Group representative should notify the Isle of Wight Safeguarding Children Partnership Team (via email: scp@iow.gov.uk) of a referral and confirm this in writing using the referral form. It is the decision of the representatives of the safeguarding partners who are members of LIG to consider and agree whether a case meets the criteria for a serious incident notification. If the decision of the safeguarding partners is that the referral does not meet the

[4] National Child Safeguarding Practice Reviews are undertaken by the Child Safeguarding Practice Review Panel.

criteria for a serious incident notification, it is then the decision of the chair of the Learning Inquiry Group whether the referral should be:

- Discussed by the Learning Inquiry Group (supported by scoping of agency information).
- Discussed at a safeguarding leads meeting.
- No further action taken.

Section B

Serious Incident Notifications

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 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.

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

The decision to notify rests with the safeguarding partner representatives attending LIG. The duty to notify serious incidents to the Child Safeguarding Practice Review Panel rests with the local authority and they should do so **within five working days** of becoming aware that the incident has occurred. 'Working Together to Safeguard Children' provides further information on this reporting duty.

Where safeguarding partners agree a serious incident notification should be made, they will ensure that the serious incident notification is reported locally to the Isle of Wight Safeguarding Children Partnership Independent Scrutineer and Strategic Partnership Manager **within five working days**.

The local authority must also notify the Secretary of State and Ofsted where a Looked After Child has died, whether or not abuse or neglect is known or suspected. The local authority also has a non-mandatory responsibility to notify of the death of a care leaver aged up to and including 24 years.

The Child Safeguarding Practice Review Panel have provided guidance[5] to outline the decision-making process around serious incident notifications. IOWSCP have produced the flowchart below for additional clarity:

	Action	Timescale
1	A referral is made to the IOWSCP LIG (via scp@iow.gov.uk)	
2	IOWSCP Team to share the referral with the Chair of LIG and Service Director of Children's Social Care	Within 1 working day

[5] Child Safeguarding Practice Review Panel (2022), Child Safeguarding Practice Review Panel Guidance for Safeguarding Partners

3	The referral is reviewed by the Chair of LIG and Service Director of Children's Social Care. An initial view and rationale is shared with the IOWSCP Team, who share it with the agreed safeguarding partners (representatives in LIG).	Within 1 working day
4	Safeguarding partners to review the referral and initial view and provide their response and rationale (reply to all). Nil response within the time frame will be accepted as agreement with the views provided.	Within 1 working day of receipt
5	In the situation that any differences cannot be resolved by email, IOWSCP to arrange a short meeting within 1 working day and representatives of the safeguarding partners in LIG and they will prioritise attendance.	Within 1 working day
6	In exceptional circumstances where differences of view cannot be resolved, IOWSCP will arrange a short meeting within 1 working day with the IOWSCP Partnership Chair (as decision maker) and Independent Scrutineer (as mediator).	Within 1 working day

Rapid Reviews

Following a serious incident notification, responsibility for undertaking the rapid review (or, in exceptional circumstances, the decision not to undertake a rapid review) rests with the Learning and Inquiry Group on behalf of the safeguarding partners.

Local safeguarding partners are required to undertake a rapid review **within fifteen working days of the submission of the serious incident notification**.

On receipt of the serious incident notification, the Isle of Wight Safeguarding Children Partnership Team will request a Learning Inquiry Group referral form is completed, as necessary.

An extraordinary meeting of the Learning Inquiry Group may be convened to discuss the case. Children's Services, Police and the Integrated Care Board (ICB) representation is required for the meeting to be quorate.

The purpose of a rapid review is to establish the following as quickly as possible:

- Gather the facts about the case, as far as they can be readily established at the time.
- Discuss whether there is any immediate action needed to ensure children's safety[6] and share any learning appropriately.
- Consider the potential for identifying improvements and, where possible, identify necessary improvements to safeguard and promote the welfare of children.
- Decide what steps they should take next, including whether to undertake a local child safeguarding practice review.

All members of LIG are committed to the following:

1. To provide IOWSCP with scoping information by the required date to enable adequate reading time for all LIG members.
2. All LIG members will come prepared for all rapid review discussions having read all the associated scoping documents.

[6] This includes siblings. When a child dies or is seriously harmed, and abuse or neglect is known or suspected to be a factor, the Learning and Inquiry Group will require information on whether there are other children who are suffering, or likely to suffer, significant harm and who require safeguarding for example, siblings or other children in a family network, institution or social network (including social media) within which abuse is alleged and what action has been taken to ensure this. Where there are concerns about the welfare of siblings or other children, the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Safeguarding Children Partnerships' Child Protection Procedures will be followed, including those covering organised and complex abuse if relevant.

3. All rapid review discussions will be based on restorative practice principles, including high support, high challenge, curiosity and learning.
4. LIG members following their review of the scoping information will come prepared to share their reflections, areas of interest, key points and questions.
5. Time will be focused on multi-agency reflection by LIG members considering the areas highlighted, in order to identify effective practice, areas of further learning, and/or key lines of enquiry that should be taken forward.
6. Safeguarding partner representatives in LIG, with the support of all LIG members will make the decision whether a local child safeguarding practice review is required.
7. All rapid review discussions will be considered against agreed LIG case discussion quality standards.

Quality standards for discussions:

- All equality, equity, diversity and inclusion factors for the child and family are considered within our discussion of multi-agency safeguarding practice, including intersectionality.
- We are curious and questioning, testing out and challenging assumptions.
- We use critical thinking skills to support our analysis of our own agency and multi-agency safeguarding practice and been mindful of our own, others and collective conscious or unconscious bias. Our focus has been "what does this mean for the child?"
- We are honest in our discussions, collectively open to learning, using strengths-based language, listening to hear and not to respond.
- We focus on the lived experience of the child, using our multi-disciplinary expertise.

A rapid review will include a decision from safeguarding partners about whether a local child safeguarding practice review should be commissioned using the criteria set out in 'Working Together to Safeguard Children.' If the decision is to undertake a local child safeguarding practice review, the rapid review will include the key lines of enquiry for the local child safeguarding practice review as far as they are understood at the time. The rapid review may include the methodology proposed for the local child safeguarding practice review, as far as is known.

Please note: A rapid review may negate the need for a local child safeguarding practice review where the rapid review has identified the learning, effective practice and has made necessary recommendation(s) to improve safeguarding practice.

The recommendations and actions arising from a rapid review are monitored and assured through the Learning Inquiry Group.

Locally, the information for the rapid review is collated through 'summary of involvement requests' which are shared with all Learning Inquiry Group members for completion and any other relevant agencies identified. Where the child has died, the Learning Inquiry Group will also use information available from the professionals involved in reviewing the child's death to assist in making this decision.

On completion of the rapid review, the Isle of Wight Safeguarding Children Partnership Team will share the Rapid Review with the:

- Chair of the Learning Inquiry Group for approval and Learning Inquiry Group members for their information.
- Safeguarding partners and the Isle of Wight Safeguarding Children Partnership Independent Scrutineer for the purposes of scrutiny.
- Child Safeguarding Practice Review Panel and Ofsted.

Please note, any decision not to undertake a rapid review following a serious incident notification must be notified to the Child Safeguarding Practice Review Panel with the rationale for the decision, as agreed by the safeguarding partners with oversight of the Isle of Wight Safeguarding Children Partnership Independent Scrutineer.

The Child Safeguarding Practice Review Panel have provided further information in 'Child Safeguarding Practice Review Panel Guidance for Safeguarding Partners' (2022)[7] and 'Rapid Review Examples' (2022)[8] to support safeguarding partners.

Local Child Safeguarding Practice Reviews

5.1 Purpose

'Working Together to Safeguard Children' states that, "The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children… Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations, or agencies to account."[9]

5.2 Criteria for a Local Child Safeguarding Practice Review

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. [10]

When considering whether a local child safeguarding practice review should be undertaken, Learning Inquiry Group members must consider whether the case:

- Highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have previously been identified.
- Highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children.
- Highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children.
- Is one which the Child Safeguarding Practice Review Panel have considered and concluded a local Child Safeguarding Practice Review may be more appropriate.

Learning Inquiry Group members should also have regard to circumstances where:

[7] Child Safeguarding Practice Review Panel (2022), Child Safeguarding Practice Review Panel Guidance for Safeguarding Partners.
[8] Child Safeguarding Practice Review Panel (2022), Rapid Review Examples.
[9] HM Government, Working Together to Safeguarding Children.
[10] Issues that 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.

- The safeguarding partners have cause for concern about the actions of a single agency.
- There has been no agency involvement, and this gives the safeguarding partners cause for concern.
- More than one local authority, police area or integrated care board (ICB) is involved, including in cases where families have moved around.
- Where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.

5.3 Decision Making

The safeguarding partners have responsibility for deciding whether to commission and conduct a local child safeguarding practice review. The Independent Scrutineer will also be informed, to allow scrutiny of the decision-making process. If new information becomes known during a local child safeguarding practice review, which suggests that a national child safeguarding practice review may be appropriate, the Isle of Wight Safeguarding Children Partnership Team (with agreement of the chair of the Learning Inquiry Group, the safeguarding partners and the oversight of the Independent Scrutineer) will inform the national Child Safeguarding Practice Review Panel.

Decisions on whether to undertake reviews should be made transparently and the rationale communicated appropriately, including to families.

5.4 Responsibilities

The Isle of Wight Safeguarding Children Partnership are responsible for overseeing local child safeguarding practice reviews.

The Child Safeguarding Practice Review Panel are responsible at a national level for overseeing the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance (national child safeguarding practice review).

5.5 Deciding which Local Authority should take Lead Responsibility

The Local Safeguarding Children Partnership for the area in which the child is normally resident decides whether the referral meets the criteria for a local child safeguarding practice review. Any other partnerships that have an interest or involvement in the case should be invited to be included as partners in jointly planning, undertaking the review, and identifying the recommendations for learning and improvement.

The Isle of Wight Safeguarding Children Partnership cannot instruct another partnership to carry out a review (and vice versa) but must ensure the responsibilities are clearly communicated to other partnerships. Where another partnership does not agree with an action or fails to carry it out, the Learning Inquiry Group should seek clarification of the reasons why and, if necessary, escalate the issues to the chair of Learning Inquiry Group.

In the case of looked after children, the local authority with statutory responsibility for the looked after child should take lead responsibility for conducting the review, again involving other partnerships with an interest or involvement.

5.6 Notifications of a decision to undertake a local child safeguarding practice review

As part of the rapid review, the Isle of Wight Safeguarding Children Partnership Team will inform the Child Safeguarding Practice Review Panel, Ofsted and Department for Education (DfE)[11] , on behalf of the safeguarding partners of the decision regarding whether a local child safeguarding practice review is required, and about their next steps, including the name of any reviewer commissioned where known. The decision may be subject to scrutiny by the Child Safeguarding Practice Review Panel. IOWSCP Partnership Team will also inform the Chief Caseworker Unit[12] on behalf of the safeguarding partners of any review which is believed to require a migration, border or citizenship related contribution from the Home Office.

Where the Isle of Wight Safeguarding Children Partnership has decided to carry out a local child safeguarding practice review, a letter of notification will be sent to the Isle of Wight Safeguarding Children Partnership executive (including delegated safeguarding partners) and board members.

5.7 Reviewers and Scrutineers

The Learning Inquiry Group leads on the commissioning and oversight of local child safeguarding practice reviews, on behalf of the Isle of Wight Safeguarding Children Partnership.

Reviewers from the Child Safeguarding Practice Review Panel's pool of reviewers can be appointed for local child safeguarding practice reviews, where available, as well as reviewers from Isle of Wight agencies (providing the Learning Inquiry Group can be assured of their independence).

When commissioning a reviewer, the following will be considered:

a) Professional knowledge, understanding and practice relevant to local child safeguarding practice reviews, including the ability to engage both with practitioners, children and families.
b) Knowledge and understanding of research relevant to children's safeguarding issues.
c) Ability to recognise the complex circumstances in which practitioners work together to safeguard children.
d) Ability to understand practice from the viewpoint of the individuals, organisations or agencies involved at the time rather than using hindsight.
e) Ability to communicate findings and any recommendations effectively.
f) Any real or perceived conflict of interest.

A decision will be made dependent on the case as to whether an external[13] or internal[14] independent reviewer will be commissioned to lead the review. The Learning Inquiry Group

[11] Mailbox.NationalReviewPanel@education.gov.uk
SCR.SIN@ofsted.gov.uk
Mailbox.CPOD@education.gov.uk
[12] CCUsafeguarding@homeoffice.gov.uk
[13] An External Independent reviewer is one who has not previously worked for any of the Isle of Wight Partnership agencies within the past five years.
[14] An Internal Independent reviewer is a senior professional who is employed by an Isle of Wight Partnership agency but has not had direct involvement in the case or any line management responsibility of professionals involved in the case.

chair and the Isle of Wight Safeguarding Children Partnership Team will identify suitable candidates, dependent on the needs of each case. External reviewers will be asked to supply:

- A Curriculum Vitae.
- A referee who will be a senior manager or partnership chair in an authority where they have previously been a reviewer.
- Evidence of appropriate levels of insurance and professional indemnity.

If an external reviewer has been identified, a commissioning letter and contract outlining terms and conditions for the case review will be drawn up by the Isle of Wight Safeguarding Children Partnership Team. The contract will include details of the time allocated, costs agreed, timescales for completion and the format of the final report. The lead reviewer is likely to be commissioned to produce the report. However, this needs to be confirmed on a case-by-case basis.

The Learning Inquiry Group, on behalf of the Isle of Wight Safeguarding Children Partnership, may remove a reviewer from a review at any time prior to the publication of the local child safeguarding practice review report or any information relating to improvements.

Learning Inquiry Group members may decide to commission independent scrutiny of a local child safeguarding practice review. This is commissioned using the same approach outlined above in respect of external reviewers and includes defined tasks for scrutiny within the contract.

5.8 Methodology of the Review

The Learning Inquiry Group will agree with the reviewer(s) the method by which the review should be conducted. The methodology will be consistent with the principles in 'Working Together to Safeguard Children' [15] and the systems methodology recommended by the Munro Review[16].

The methodology will consider front line practice as well as organisational structures and learning, to identify improvements to local practice and wider systems. The methodology will be chosen to deepen understanding regarding how the child safeguarding system is operating, including the effectiveness of practice and challenges encountered by agencies. The methodology must result in clear and achievable recommendations that will improve outcomes for children.

The Terms of Reference, including the areas of focus, for the review will be agreed by the Learning Inquiry Group and the reviewer. This may include links to previous learning, identified through multi-agency case file audits or previous reviews.

5.9 Engagement of Agencies and Organisations

The Learning Inquiry Group will ensure that there is appropriate representation in the review process of professionals and organisations who were involved with the child and family. The

[15] HM Government, Working Together to Safeguarding Children.

[16] Eileen Munro (2011), The Munro Review of Child Protection: Final Report: A Child Centred System.

priority will be to engage organisations to ensure that key factors in the case can be identified, and appropriate action taken to make improvements.

Guidance issued by the President of the Family Division on judicial cooperation with reviews[17] advises that the judiciary do not need to participate in the process. It is understood that the judiciary takes this stance to protect their independence and the independence of individual judges. Where relevant, the Isle of Wight Safeguarding Children Partnership will share final reports, and the findings from these reviews, with the President of the Family Division in the understanding they will disseminate these to the wider judiciary.

Consideration needs to be given to the impact of the review on parallel processes and vice versa. Practitioners may be witnesses in criminal proceedings, therefore discussion with the senior investigating officer needs to take place prior to frontline staff being engaged in the process.[18]

5.10 Engaging Family Members

As part of its duty to ensure that the experiences of children and families are at the heart of learning in child safeguarding practice reviews, the Isle of Wight Safeguarding Children Partnership will always, where possible, seek to ensure that families, including surviving children, are invited to contribute. They will be supported to understand their involvement and their expectations will be managed appropriately and sensitively.

Effective communication at an early stage is vital in gaining cooperation from family members during the local child safeguarding practice review process. The use of interpreters or translation services will be used where English is not the first language of the family members. Locally, best practice is to arrange for a practitioner working closely with the family to personally deliver and explain the context using a bespoke letter from the partnership to support this. It is not effective practice for a letter to be sent without prior knowledge to family members, unless every reasonable attempt to arrange a face-to-face interview has been exhausted. In such situations, the wording of any communication will be carefully considered.

The timings of informing family members are crucial, particularly when there are current police investigations. When there are pending criminal proceedings involving the parents and/or family members, the decision about how and when to notify the family will be discussed with the Learning Inquiry Group police representative in conjunction with the senior investigating officer.

The family will be invited to share their views with the reviewer or representative from the Isle of Wight Safeguarding Children Partnership when appropriate.

If, during the local child safeguarding practice review, third parties are identified whom it is considered can offer an important perspective on the case (such as friends or key members of the network of the family), there will be consideration as to how best to invite them to participate in the review by meeting with the reviewer. The means of notifying them of the request should be the subject of careful consideration, informed by their circumstances.

[17] President of the Family Division (2017), President's Guidance Judicial Cooperation with Serious Case Reviews.

[18] Crown Prosecution Service (2020), Protocol for Liaison and Information Exchange when criminal proceedings coincide with Child Safeguarding Practice Reviews in England.

5.11 Involving and Supporting Practitioners

Practitioners should be fully involved in local child safeguarding practice reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith. The death or serious injury of a child is a traumatic event for involved staff (including unpaid staff, such as volunteers), particularly if they worked with the involved child or the child's family.

Managers have a duty of care to employees and volunteers and should ensure staff involved are supported throughout the process. This might be by the provision of support from the employer or by giving advice about sources of independent support. Managers should advise staff about access to support through the employing agency (for example, many organisations have employee welfare services which may be able to assist). In addition, or as an alternative, staff may also wish to consult their Trade Union or professional association about sources of support. Managers should not prevent or discourage this. 5

5.12 Supporting the Review

The Learning Inquiry Group will support the review to ensure that the reviewer is making satisfactory progress. This will be actively monitored against the timescales as set out in the contract agreed with the reviewer. Where there are other proceedings which run parallel to a local child safeguarding practice review, the Learning Inquiry Group will ensure the reviewer and/or the Isle of Wight Safeguarding Children Partnership team works closely with those responsible to avoid one process jeopardising or unnecessarily delaying the other.

5.13 Reviewing Institutional or Complex Abuse[19]

When serious abuse takes place in an institution, or multiple abusers are involved, the same principles of a local child safeguarding practice review apply but the local child safeguarding practice review is likely to be more complex, on a larger scale, and may require more time.

The Learning Inquiry Group will seek clarity over the interface between:

- The different processes of investigation (including criminal investigations).
- Case-management, including help for abused children and immediate measures to ensure that other children are safe.
- The local child safeguarding practice review (i.e., learning lessons from the case to reduce the chance of such events happening again).

The three different processes should inform each other. Any proposals for review should be agreed with those leading criminal investigations, to make sure that they do not prejudice possible criminal proceedings.

[19] "Institutional settings" includes:
(a) Children's homes (including secure children's homes) and other settings with residential provision for children.
(b) Custodial settings where a child is held, including police custody, young offenders' institutions and secure training centres.
(c) All settings where detention of a child takes place including under the Mental Health Act 1983 or the Mental Capacity Act 2005

5.14 Form and Content of Final Draft Report

The report must be of satisfactory quality and include:

- An analysis of the systemic or underlying reasons why actions were taken or not taken in respect of matters covered by the report.
- A summary of recommended improvements for the safeguarding partners or others to safeguard and promote the welfare of children and identification of effective practice.
- Recommendations, which must be SMART (specific, measurable, achievable, realistic and timely) and provide clarity regarding the expected impact.
-

Local child safeguarding practice review reports will be:

- Written in plain English and in a way that can be easily understood by professionals and the public alike.
- Suitable for publication without needing to be amended or redacted.
- Anonymised so that it is not possible to identify the child, the family, practitioners, or other individuals involved with the case.

Any recommendations which are made will be clear on what is required of relevant parties collectively and individually and focused on improving outcomes for children. Where there are recommendations in respect of specific agencies, those agencies should be sighted on the recommendations prior to approval.

5.15 Action on Receiving the Final Draft Report (Including Approval)

The Learning Inquiry Group will quality assure the final draft of the report and the accompanying Isle of Wight Safeguarding Children Partnership response to the local child safeguarding practice review which details the activity already taken in response to the review findings.

The Isle of Wight Safeguarding Children Partnership Learning Inquiry Group will oversee the process of agreeing with all partners what action they need to take in light of the review's findings.

The Isle of Wight Safeguarding Children Partnership Executive will approve the:

- Final report
- Isle of Wight Safeguarding Children Partnership response
- Action Plan
- Publication plan, including a media statement as appropriate; prior to publication the Isle of Wight Safeguarding Children Partnership and that all relevant partner agencies will anticipate the likely response from the media and plan how to manage it constructively. A lead agency may take responsibility for responding to media interest about a case, in liaison with contributing agencies and professionals.

Please note: The Isle of Wight Safeguarding Children Partnership Executive Group decide on publication, including the documents to be published. This may include a decision not to publish any review documentation. This decision is made in the best interests of the children and family members. Where publication does not happen, the Executive must give

consideration as to how to effectively disseminate learning. This should be included in any action plan and monitored by the Learning Inquiry Group.

The Learning Inquiry Group will:

- Provide feedback and debriefing to family members as appropriate.
- Provide feedback and debriefing to staff as appropriate.
- Share with the Isle of Wight Safeguarding Children Partnership Main Board for information.
- Disseminate the final local child safeguarding practice review report and response to relevant interested parties.
- Publish the final local child safeguarding practice review report/learning and response and/or plan for the dissemination of learning.
- Implement those actions for which the Isle of Wight Safeguarding Children Partnership has lead responsibility and monitor the timely implementation of all the actions resulting from the review.
- Formally conclude the review process when all the actions have been implemented.

5.16 Timescales for Local Child Safeguarding Practice Reviews

Depending on the nature and complexity of the case, reports should be completed and published within **six months** from the date of the decision to initiate a review.

Where other proceedings may have an impact on or delay publication, for example, an ongoing criminal investigation, inquest or future prosecution, the Isle of Wight Safeguarding Children Partnership Team will inform the Child Safeguarding Practice Review Panel and the Secretary of State of the reasons for the delay.

5.17 Parallel Processes

There will be instances where a local child safeguarding practice review has been carried out which could then form part of a thematic review that the Child Safeguarding Practice Review Panel undertakes at a later date. There may also be instances when a local child safeguarding practice review has not been carried out but where the Panel considers that the case could be helpful to a national review at some stage in the future. In such circumstances, the Child Safeguarding Practice Review Panel should engage with the Isle of Wight Safeguarding Children Partnership to agree the conduct of the review.

The Child Safeguarding Practice Review Panel have their own processes for how they will work with other investigations.

Locally, if another type of review, for example a Domestic Homicide Review, Multi-Agency Public Protection Arrangements (MAPPA), or Safeguarding Adults Review, is being carried out, the Isle of Wight Safeguarding Children Partnership will work collaboratively with those responsible for carrying out those reviews. This is to minimise duplication of effort, uncertainty and/or confusion relating to the different review processes and reduce burdens on and anxiety, for the families and children concerned.

In some cases, criminal proceedings may follow the death or serious injury of a child. The Isle of Wight Safeguarding Children Partnership Team will discuss with the relevant criminal justice agencies such as the police and the Criminal Prosecution Service, at an early stage, how the local child safeguarding practice review process should take account of such proceedings.[20]

Where a child has died, their death may be the subject of an inquest conducted by the coroner. The function of the inquest will be to establish the circumstances and cause of the death. Consideration will be given on a case-by-case basis as to the degree to which any local child safeguarding practice review needs to be informed by the inquest, and vice versa, and this will have implications for the timescales of any review. In any such event, the relevant Learning Inquiry Group police representative will inform the coroner that a local child safeguarding practice review is being undertaken.

The LIG police representative will consider at an early stage the degree to which it will be necessary in the circumstances of the case for the local child safeguarding practice review to have access to information which may emerge from the enquiries of the coroner, and the subsequent inquest. The coroner will also wish to consider the extent to which it will be necessary to receive relevant information from the review, or even whether the inquest can proceed prior to the review concluding. These are issues which should be considered with the benefit of legal advice by the reviewer(s), the Learning Inquiry Group chair and the Isle of Wight Safeguarding Children Partnership Independent Scrutineer, and then raised with the coroner on behalf of the Isle of Wight Safeguarding Children Partnership at the first pre-inquest review hearing.

Staff involved in any local child safeguarding practice review should be informed that there is legal precedent for the coroner asking to see the material obtained during any review process, and that therefore it is possible that information shared during the local child safeguarding practice review will be shared with the coroner, who can then decide to disclose any part of the information obtained in the inquest with any interested party to the inquest, including the family. Where agencies participating in the local child safeguarding practice review are also made interested parties to the inquest, it will be possible for staff to seek their own legal advice about this, and if necessary, their agency can make its own representations to the coroner. Where possible, family members should be met with and made aware of review findings prior to receiving any review documents via the coroner's court.

If there are proceedings which have been, or are being, conducted in the family court at the time of the local child safeguarding practice review, the Children's Services representative will be requested to consider whether there is any relevant information pertinent to the terms of the local child safeguarding practice review obtained within the family proceedings. If this is the case, the Children's Services representation should advise whether an application to the family court is needed for disclosure of the identified material to the review team.

Local child safeguarding practice reviews should not be delayed as a matter of course because of outstanding family, civil or administrative court cases or coroners' proceedings. The reviewer/Isle of Wight Safeguarding Children Partnership will consult appropriately when there are any dual court processes, for example, pending criminal, civil proceedings, and where necessary having obtained legal advice.

[20] Crown Prosecution Service (2020), Protocol for Liaison and Information Exchange when criminal proceedings coincide with Child Safeguarding Practice Reviews in England.

The final report will take full account of salient, new information which becomes available during these and any civil or criminal proceedings, and the facts, conclusions and recommendations should be revised accordingly.

'Working Together to Safeguard Children'[21] is clear that employers have the responsibility for considering whether any disciplinary action should be taken against practitioners whose conduct and/or practice falls below acceptable standards and should refer to their regulatory body as appropriate. There are processes in place to hold individuals, organisations and agencies to account, including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings. Whilst these processes may be carried out alongside reviews or at a later stage, they remain separate to the review purpose and process.

5.18 Publication and Dissemination of Learning

Local child safeguarding practice reviews are focused on promoting and sharing learning. The Isle of Wight Safeguarding Children Partnership will therefore publish the report, unless there are exceptional circumstances where it would be inappropriate to do so. In such circumstances, the Isle of Wight Safeguarding Children Partnership must publish any information about the improvements that should be made following the review that they consider it appropriate to publish. The name of the reviewer(s) should be included. Published reports or information must be publicly available for a minimum of one year.

Reports should be anonymised and written in such a way that the published content avoids identifying or harming the welfare of any children or vulnerable adults involved in the case.

The Isle of Wight Safeguarding Children Partnership Team will send a copy of the full report to the Child Safeguarding Practice Review Panel and to the Secretary of State no later than **seven working days** before publication. They will confirm and share what is being published and when and set out for the Panel and the Secretary of State the justification for any non-publication, or delay to publication, if applicable. The Child Safeguarding Practice Review Panel provide further information regarding the publication of child safeguarding practice reviews. [22]

The Data Protection Act 2018 [23] will be complied with, and the Isle of Wight Safeguarding Children Partnership will also comply with any other restrictions on publication of information, such as court orders which restrict published material about the family. Where a report has been provided to the coroner's inquest prior to publication it should be noted that the inquest is held in public, and therefore there will be scope for publishing details of the report as far as it is made public during the inquest.

It is expected that the Isle of Wight Safeguarding Children Partnership and partner agencies will disseminate learning through relevant communication methods and training as required. This may include briefing sessions, newsletters, practitioner briefings and the Isle of Wight Safeguarding Children Partnership Yearly Report.

[21] HM Government , Working Together to Safeguarding Children.

[22] Child Safeguarding Practice Review Panel (2022), Child Safeguarding Practice Review Panel Guidance for Safeguarding Partners.

[23] HM Government (2018), Data Protection Act

Section C

Local Learning Events

6.1 Introduction: Local Learning Events

There will be referrals which are considered by the Learning Inquiry Group where the criteria for a serious incident notification and therefore a rapid review have not been met. In these instances, scoping will be undertaken at the direction of the chair of the Learning Inquiry Group and within agreed timescales to ensure members of the Learning Inquiry Group are able to consider the referral in a timely way. This decision is open to the scrutiny of the safeguarding partners. Where it is considered that there is further work required to identify and clarify multi-agency learning, particularly new learning for the multi-agency safeguarding system and/or raises issues of importance for the local area, Learning Inquiry Group members may agree a local learning event is necessary.

6.2 Purpose of a Local Learning Event

The purpose of a local learning event remains the same as that of a local child safeguarding practice review, which is to identify learning, effective practice and any improvements required to safeguard and promote the welfare of children. Local learning events seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations, or agencies to account but are intended to identify learning in a proportionate and expedient way.

6.3 Considerations for a Local Learning Event

A local learning event may be undertaken for cases where the Learning Inquiry Group have collectively decided that further work is required to identify and clarify multi-agency learning from the case using the following considerations:

- The case raises issues of local importance for the multi-agency safeguarding system.
- There has been good practice/poor practice or a near miss event.
- Previous learning is identified which may indicate a need to assure impact on practice.
- There are indications of new learning for the multi-agency safeguarding system.

In addition, Learning Inquiry Group members will also consider if the multi-agency learning, or assurance work required could be achieved more effectively through another Isle of Wight Safeguarding Children Partnership workstream (for example, multi-agency auditing).

6.4 Decision Making

The safeguarding partners have the responsibility for deciding whether to conduct a local learning event. If during a local learning event, new information becomes known which suggests that a serious incident notification should be completed, the Isle of Wight Safeguarding Children Partnership Team will inform the chair of the Learning Inquiry Group and the safeguarding partners.

Decisions on whether to undertake local learning events should be made transparently and the rationale captured in the Learning Inquiry Group meeting minutes and Terms of Reference for the local learning event, including the key lines of enquiry and proportionate methodology.

6.5 Responsibilities

The Learning Inquiry Group are responsible for overseeing the undertaking of local learning events, on behalf of the Isle of Wight Safeguarding Children Partnership. This includes responsibility for defining and agreeing the Terms of Reference.

6.6 Deciding which Local Agencies should take Lead Responsibility

The Learning Inquiry Group will decide which agencies should take responsibility for leading the local learning event. The decision will be made taking into consideration the level and nature of agency involvement in the case. Typically, local learning events are co-led by two members of the Learning Inquiry Group, who represent one of the safeguarding partners (Isle of Wight Council Children's Services, Hampshire and Isle of Wight Constabulary and the Hampshire and Isle of Wight Integrated Care Board). However, there will be cases where it is appropriate for a local learning event to be led or co-led by a Learning Inquiry Group member representing a different agency.

6.7 Safeguarding Siblings or Other Children

When a case is referred to the Learning Inquiry Group for discussion, the Learning Inquiry Group require information on whether there are other children who are suffering, or likely to suffer, significant harm and who require safeguarding for example, siblings or other children in a family network, institution or social network (including social media) within which abuse is alleged and what action has been taken to ensure this.

Where there are concerns about the welfare of siblings or other children, the Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Safeguarding Children Partnerships' Child Protection Procedures[24] will be followed, including those covering organised and complex abuse if relevant.

6.8 Methodology of the Local Learning Event

The Learning Inquiry Group will agree the method by which the local learning event should be conducted. The methodology will be proportionate and consistent with the principles in Chapter 5 of 'Working Together to Safeguard Children'[25] and the systems methodology recommended by the Munro Review.[26]

[24] Hampshire Isle of Wight, Portsmouth and Southampton (HIPS) Safeguarding Children Partnerships' Child Protection Procedures.

[25] HM Government, Working Together to Safeguarding Children.

[26] Eileen Munro (2011), The Munro Review of Child Protection: Final Report: A Child Centred System.

The methodology will provide a way of looking at and analysing front line practice as well as organisational structures and learning. The methodology must reach recommendations that will improve outcomes for children.

The initial scoping of the local learning event will consider the current information known in each case and identify those who should contribute. As further information becomes available, other contributors may be needed. There will be specific questions identified through LIG that should be answered as part of the local learning events. These may link to previous lessons learnt through monitoring and evaluation (for example, through multi-agency case audits or from previous local learning events or local child safeguarding practice reviews).

6.9 Engagement of Agencies and Organisations

The Learning Inquiry Group will ensure that there is appropriate representation in the local learning event process of professionals and organisations who were involved with the child and family, where this representation is required. The priority will be to engage organisations in a proportionate way, to ensure that key factors in the case can be identified and appropriate action taken to make improvements.

Consideration needs to be given to the impact of the local learning event on any parallel processes. Practitioners may be witnesses in criminal proceedings, therefore discussion with the police Learning Inquiry Group representative and senior investigating officer needs to take place prior to frontline staff being engaged in the process.[27]

6.10 Engaging Family Members

The Learning Inquiry Group will consider child and family member contribution to the local learning event. If contribution is sought, then children and family members will be supported to understand how they are going to be involved and their expectations will be managed appropriately and sensitively.

Effective communication at an early stage is vital in gaining cooperation from family members during the local learning event process if they are going to be invited to be involved (for example, through interviews). The use of interpreters or translation services will be used where English is not the first language of the family members.

If the Learning Inquiry Group decide that the child or family will be invited to contribute to the local learning event, then the timings of communication with the child and family are crucial, particularly if there are current police investigations. Where there are pending criminal proceedings involving the parents and or family members, the decision about how and when to communicate with the family will be discussed with a police representative.

If, during the local learning event, third parties are identified who could offer an important perspective on the case (such as friends or key members of the network of the family), there will be consideration as to how best to invite them to participate in the local learning event by

[27] Crown Prosecution Service (2020), Protocol for Liaison and Information Exchange when criminal proceedings coincide with Child Safeguarding Practice Reviews in England

meeting with the local learning event leads. The means of communicating the request should be the subject of careful consideration, informed by their circumstances.

6.11 Involving and Supporting Practitioners

Where practitioners are involved in local learning events, for example in a practitioner workshop, they should be invited to contribute their perspectives without fear of being blamed for actions they took in good faith. The death or serious injury of a child is a traumatic event for involved staff (including unpaid staff such as volunteers), particularly if they worked with the child or to the child's family.

Managers have a duty of care to employees and volunteers and should ensure staff involved are supported through the process. This might be by the provision of support from the employer or by giving advice about sources of independent support. Managers should advise staff about access to support through the employing agency (for example, many organisations have employee welfare services which may be able to assist). In addition, or as an alternative, staff may also wish to consult their Trade Union or professional association about sources of support. Managers should not prevent or discourage this.

6.12 Supporting the Local Learning Event

The Learning Inquiry Group will oversee the local learning event process to ensure that the event leads are making satisfactory progress. This will be actively monitored against the timescales agreed with the Learning Inquiry Group. Where there are other proceedings which run parallel to a local learning event, the Learning Inquiry Group will ensure the event leads work closely with those responsible to avoid one process jeopardising or unnecessarily delaying the other.

6.13 Form and Content of Final Report

The final report must be of satisfactory quality and include:

- A summary of any recommended improvements to safeguard and promote the welfare of children.
- An analysis of the systemic or underlying reasons why actions were taken or not taken in respect of matters covered by the report.
- Recognition of effective and/or excellent practice.
- Recommendations must be SMART and provide clarity regarding the expected impact.

Final local learning event reports will be:

- Written in plain English and in a way that can be easily understood by professionals.
- Anonymised so that it is not possible to identify the child, the family, practitioners, or other individuals involved with the case.

Reports produced for a local learning event will be succinct to enable use as case studies in safeguarding practice development. Any recommendations which are made will be clear on what is required of relevant parties collectively and individually and focused on improving

outcomes for children. Where there are recommendations in respect of specific agencies, those agencies should be sighted on the recommendations prior to approval.

The final report should be completed within **four months**.

6.14 Action on Receiving the Final Report (Including Approval)

The Learning Inquiry Group, on behalf of the Isle of Wight Safeguarding Children Partnership, will quality assure the final draft of the report.

The Isle of Wight Safeguarding Children Partnership LIG will oversee the process of agreeing with all partners what action they need to take in light of the local learning event's findings.

The Isle of Wight Safeguarding Children Partnership Executive will approve the final report and via the Learning Inquiry Group will:

- Plan to provide feedback and debriefing to family members as appropriate.
- Plan to provide feedback and debriefing to staff as appropriate.
- Implement those actions for which the Isle of Wight Safeguarding Children Partnership has lead responsibility.
- Monitor the timely implementation of all the actions resulting from the local learning event for single and multi-agencies, the impact these actions have had on improving services and what more will be done.
- Share the local learning event report with the Isle of Wight Safeguarding Children Partnership Main Board for information.
- Plan for the dissemination of learning and monitor that learning is shared across the partnership.
- Formally conclude the local learning event process when all the actions have been implemented.

6.15 Dissemination of Learning

Local Learning Events are focused on promoting and sharing information about improvements, so on behalf of the Isle of Wight Safeguarding Children Partnership, the Learning Inquiry Group will monitor the dissemination of learning and implementation of the actions resulting from the local learning event. While local learning event reports are not required to be published, it is expected that the Isle of Wight Safeguarding Children Partnership and partner agencies will disseminate learning through relevant communication methods and training as required. This may include briefing sessions, newsletters, practitioner briefings and the Isle of Wight Safeguarding Children Partnership Yearly Report.

6.16 Timescales for Local Learning Events

Depending on the nature and complexity of the case, local learning events reports should be completed and ready for approval within **four months** from the date of the decision to initiate a local learning event.

Where other proceedings may have an impact on or delay the local Learning Event, for example, an ongoing criminal investigation, inquest or future prosecution, the Learning Inquiry Group will maintain oversight for assurance on behalf of the Isle of Wight Safeguarding Children Partnership.

Section D: Notification of the Death of a Care Leaver

A care leaver is anyone up to their 25th birthday and who meets both of the following criteria:

- is no longer looked-after.
- has been looked after for at least thirteen weeks which began after they reached the age of 14 and ended after they reached the age of 16.

Care leavers are entitled to support from their Personal Adviser up to their 25th birthday. Local authorities are required to keep in touch with all care leavers up to the point they reach the age of 21 and to make their best efforts to contact all care leavers aged 21 to 24 annually to remind them that they remain eligible for support. If a young person chooses not to take up support between 21 to 24 years of age, the local authority may no longer be aware of a care leaver's whereabouts or circumstances (and therefore their death).

Working Together to Safeguard Children[28] states that, "the local authority should notify the Secretary of State for Education and Ofsted of the death of a care leaver up to and including the age of 24. This should be notified via the Child Safeguarding Online Notification System". The purpose of these notifications is to allow the Department for Education to understand what has happened and inform policy decisions to prevent future deaths. This duty applies where the local authority is aware of the individual's care leaver status, regardless of abuse or neglect being present. **The death of a care leaver does not require a rapid review or local child safeguarding practice review**.

If the Care Leaver Is Under the Age of 18

In the event that the deceased care leaver was under the age of 18, safeguarding partners must consider whether the criteria for a serious incident has been met and respond accordingly. It is recognised that a majority of care leavers will have experienced neglect or abuse, often as a precursor to the child being looked after. However, such abuse or neglect, unless it is felt to be directly linked to the child's death, should be considered as background information and not as a requirement to undertake a rapid review or child safeguarding practice review. Where a care leaver has experienced recent abuse or neglect, or criminal or sexual exploitation, that is linked to the death or serious harm, then a rapid review should be undertaken.

Role of the IOWSCP Learning and Inquiry Group

The IOWSCP Learning and Inquiry Group will collect local data and information regarding any notifications of the death of a care leaver. The purpose of collecting this data and information is to support the IOWSCP LIG in identifying and responding to any emerging themes. Through collating local data and information over time, this will also allow the IOWSCP Learning and Inquiry Group to compare the local data, information and themes with the national picture.

[28] HM Government, Working Together to Safeguarding Children.

Section E: Recommendations, Auditing and Monitoring

Recommendations, Auditing and Monitoring

7.1 Recommendations, Auditing and Monitoring of National Child Safeguarding Practice Reviews, Local Child Safeguarding Practice Reviews and Local Learning Events

The Learning Inquiry Group will take account of the findings from local learning events, and local child safeguarding practice reviews to consider how identified improvements should be implemented locally, including the way in which agencies work together to safeguard and promote the welfare of children. For national child safeguarding practice reviews, LIG will consider how identified improvements should be implemented locally as required.

Recommendations arising from local child safeguarding practice reviews and local learning events should be scrutinised by Learning Inquiry Group members on behalf of the Isle of Wight Safeguarding Children Partnership as part of the approval process. Recommendations are most effective when they are SMART and few in number, as suggested by the Panel. Recommendations should provide clarity about the expected impact that is required to ensure effective monitoring by Learning Inquiry Group members. Where recommendations are noted for completion, members of the Learning Inquiry Group should be robust in seeking assurance of the expected impact of the recommendation in addition to assurance of activity completed.

Locally, improvement is sustained through regular monitoring and follow up of actions so that the review findings and local learning events make a real impact on improving outcomes for children.

Monitoring of the actions arising from recommendations will be undertaken by the Learning Inquiry Group and reported to the Isle of Wight Safeguarding Children Partnership Executive on a regular basis. Upon completion, the Learning Inquiry Group will advise the Isle of Wight Safeguarding Children Partnership Executive that all actions are complete.

Any areas of inter-agency activity identified as of particular concern may also be referred to other Isle of Wight Safeguarding Children Partnership Subgroups for action.

7.2 Embedding Learning

Child safeguarding practice reviews (local and national) and local learning events are fundamentally about learning for the multi-agency safeguarding system. It is the responsibility of the Isle of Wight Safeguarding Children Partnership agencies to ensure learning from reviews is shared within and across agencies. This is achieved through a number of ways including the Isle of Wight Safeguarding Children Partnership Yearly Report, the Isle of Wight Safeguarding Children Partnership training programme, briefings, newsletters, practitioner briefings and single agency training. How learning is shared is routinely monitored as part of the Learning Inquiry Group assurance processes and considered as part of the Keeping Children Safe Section 11 Organisational Self-Assessment.

Section E: Dispute Resolution Processes

Dispute Resolution Processes

8.1 Serious Incident Notifications

In situations where there is disagreement regarding whether a case has met the criteria for submitting a serious incident notification, it is anticipated that this will be resolved by email as set out in the decision-making process. In exceptional circumstances where agreement cannot be reached by email, IOWSCP will hold an initial meeting for the representatives of safeguarding partners at LIG. If required, a further short meeting will be held within one working day and safeguarding partners will prioritise attendance alongside the IOWSCP Partnership Chair and the IOWSCP Independent Scrutineer. Where the Independent Scrutineer is not available, they will review the records from the resolution process to support identification of any learning. Where present, the Independent Scrutineer will support mediation and provide oversight.

The IOWSCP Partnership Chair will make the final decision regarding notification, with the information known at the time.

Where the Partnership Chair has been involved in dispute resolution, should further information become available that suggests the decision to notify should be reconsidered, this should be raised via the IOWSCP Team with the Chair of LIG, the IOWSCP Partnership Chair and the IOWSCP Independent Scrutineer. The IOWSCP Partnership Chair is the decision maker.

8.2 Dispute Resolution Processes For Other Areas Of Work – Learning Inquiry Group

Where there is a disagreement regarding whether a case has met the criteria for a local learning event or that a case referral should be considered by the Learning Inquiry Group, the following dispute resolution process can be followed.

The Learning Inquiry Group safeguarding partner representatives, including the chair of the Learning Inquiry Group, will review the decision collectively and agree an outcome (within three working days).

In exceptional circumstances where a decision cannot be reached by the safeguarding partners, this will be escalated for decision by the partnership chair (within three working days).

Appendix A: Learning Inquiry Group Process Flow Chart

a. Practitioner identifies case that they believe meets the criteria as set out in Working Together
b. Discuss with Senior Manager and Learning and Inquiry Group (LIG) Representative

STAGE 1: Notification and Consideration

Referral to LIG

1. Complete **Case Referral form** and submit to IOWSCP Partnership Team.
2. Safeguarding Partners establish if the case meets the criteria for a **Serious Incident Notification.**
3. When a Serious Incident Notification has been made, a **Rapid Review** is initiated. Partnership Team discuss rapid review date with LIG Chair to decide if an additional LIG meeting is required in order to meet statutory timescales.
4. **Referral Response Form** sent to agencies by Partnership Team.
5. Agencies submit completed referral response form to Partnership Team within required timescales.
6. Partnership Team circulate papers to LIG members one week prior to meeting.

LIG meeting

7. Referring agency present the case referral form.
8. Referral response information reviewed.
9. If an LCSPR is agreed, then
    a. Type of review agreed from **Methodology Menu**
    b. Terms of Reference for review are drafted.
    c. Identification of a panel

Decision

10. Rapid Review form completed and shared with the Chair of LIG for approval. It will also be shared with LIG members for information and the IOWSCP Independent Scrutineer for the purposes of scrutiny.
11. Rapid Review form sent to Child Safeguarding Practice Review Panel and Ofsted.
12. IOWSCP Executive Group members informed.

STAGE 2: Review

Review commissioned

13. Identify and commission reviewer.
14. Family involvement considered and planned as appropriate.

Review undertaken

15. Information gathered (dependent on Methodology).
16. Engagement with family and practitioners (dependent on Methodology).
17. Oversight of the review process as standing item on LIG meeting agenda.
18. Early draft report shared with LIG chair and senior managers from partner agencies as appropriate.

Outcomes

19. Final report produced with findings and recommendations.
20. Multi-agency and single agency action plans produced.
21. Communication and media strategy agreed.
22. Final report presented to LIG by Reviewer. This is the opportunity for LIG members to raise any concerns/issues they have with the report or recommendations.
23. Partnership response to the report produced.
24. Final report taken to IOWSCP Executive for approval. This is the opportunity for Executive members to raise any concerns/issues they have with the report or recommendations and agree publication (or non-publication).
25. Final report taken to IOWSCP Main Board for ratification. This is the opportunity for Board members to raise any concerns/issues they have with the report or recommendations.
26. Outcomes shared with the family and child/children and feedback to practitioners involved in the process.

STAGE 3: Learning and Improvement

Embed learning

29. IOWSCP and partner agencies progress action plans.
30. Key messages are communicated as outlined in the communication strategy.
31. Key messages fed into single agency training.
32. Key messages fed into IOWSCP Briefing, Learning and Themes (BLT) sessions.
33. Key messages, where appropriate, fed into IOWSCP multi-agency training plan.

Evaluation

34. LIG monitors progress on actions to ensure learning is embedded in practice.
35. Evaluation of BLT sessions and IOWSCP training offer by IOWSCP Workforce Development Group.

Appendix B: Methodology Menu for Local Child Safeguarding Practice Reviews and Local Learning Events

'Working Together to Safeguard Children'[29] is clear that there is flexibility in the approach and methods used, and who leads the local child safeguarding practice review. When commissioning a local child safeguarding practice review, the Learning Inquiry Group will agree an approach that is proportionate and appropriate to the case in order to identify learning and improvement of child safeguarding practice.

Local Child Safeguarding Practice Review

A reviewer will be identified either from within Isle of Wight Safeguarding Children Partnership's member agencies (who is independent of the case/staff involved in the case), and/or an externally commissioned independent reviewer or scrutineer. A panel may be established consisting of health, children's services, police, and any identified agencies as required. Agencies involved in the case may be asked to produce further chronology and/or narrative and analysis of their involvement with the case. Meetings may be held with practitioners as required and a multi-agency workshop may be held. Family engagement will be carefully considered and facilitated as appropriate. A local child safeguarding practice review report is produced as a result of the findings and presented to the Learning Inquiry Group / Isle of Wight Safeguarding Children Partnership Executive/ Isle of Wight Safeguarding Children Partnership Main Board prior to publication. It is the responsibility of the Learning Inquiry Group to agree the methodology of the LSCSPR.

Local Learning Events

It is the responsibility of the Learning Inquiry Group to identify the method that will be used for the local learning event, to support the identification of learning and improvement of safeguarding practice. The Learning Inquiry Group may choose to use a combination of the approaches outlined below. Family engagement will be considered proportionately to the areas of focus of the local learning event.

Desktop

A desktop review of scoping and chronology information is undertaken by senior managers independent of line management of the case and identified by the Learning Inquiry Group. The lead reviewers may request additional information.

Practitioner Workshop

A practitioner workshop is led by senior managers independent of line management of the case and identified by the Learning Inquiry Group. Relevant front-line staff are identified via their agency Learning Inquiry Group member to attend the event and active participation is expected from each of the agencies involved with the child and family. The Terms of Reference and relevant information are shared with attendees in advance of the practitioner workshop, and attendees are asked to reflect on their knowledge of the case and the key questions posed by the Learning Inquiry Group, prior to attending. Practitioners attending the workshop will be encouraged to actively participate and provide additional case information, and their views will be considered alongside those of other attendees.

[29] HM Government, Working Together to Safeguarding Children

Single-Agency Learning

Please note that consideration of a case discussed by the Learning Inquiry Group may result in a single agency deciding to undertake a review within their agency. This type of work is not a local child safeguarding practice review or a local learning event, but progress and findings from the single-agency work may be monitored and shared with the Learning Inquiry Group.

Appendix C: Serious Incident Notification (SIN) Process Flowchart