This document was classified as: OFFICIAL

Learning from Reviews

Thursday 12 May 2022







& in conjunction with the Community Safety Partnerships across Tees

Aims and Objectives

You will hear about the learning from a range of reviews across Tees

You will...

- Understand the range of reviews which have taken place across Tees in recent years
- Understand the common emerging themes from reviews
- Consider the impact of these reviews on your practice
- Increase your understanding of the legal frameworks that supports work with perpetrators of abuse

What are **Learning** Reviews?

- Cases that reach the criteria are referred
- Identify with the professionals involved:
 - What is working well in the system
 - Gaps in systems
- Identification of learning for improvement leading to recommendations
- Application of learning to future cases
- Reassess embedded learning using various methods

Learning Reviews are not...

- An investigation of individuals' practice
- A chance to blame individuals or organisations
- For families to use in complaints
- However caution
 - Ongoing investigations

Our safeguarding arrangements will effectively prevent and respond to adult abuse

Children Rapid Reviews and Safeguarding Children Practice Reviews

From Working Together 2018:

- Serious child safeguarding cases are those in which:
 - abuse or neglect of a child is known or suspected and
 - the child has died or been seriously harmed

There is a statutory duty on Local Authorities to notify serious child safeguarding cases / incidents to the Child Safeguarding Practice Review Panel. The Child Safeguarding Practice Review Panel then inform the Safeguarding Children Partnership, who undertake a Rapid Review of the case and make a decision on whether a Local Safeguarding Children Practice Review (LSCPR) needs to be undertaken.

Children Rapid Reviews and Safeguarding Children Practice Reviews

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

- 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 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 or not to undertake a child safeguarding practice review.

Safeguarding Adult Reviews

The Care Act 2014 sets out the criteria for a SAR as follows:

(a) there is reasonable cause for concern about how the TSAB, its members or organisations worked together to safeguard the adult

and

(b) The adult died and the TSAB knows/suspects this was as a result of abuse or neglect

or

(c) The adult is still alive but the TSAB knows or suspects the adult has experienced serious abuse/neglect, sustained potentially life threatening injury, serious sexual abuse or serious/permanent impairment of health or development

Domestic Homicide Reviews

Section 9(3) of the Domestic Violence, Crime and Victims Act 2004

"Domestic Homicide Review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

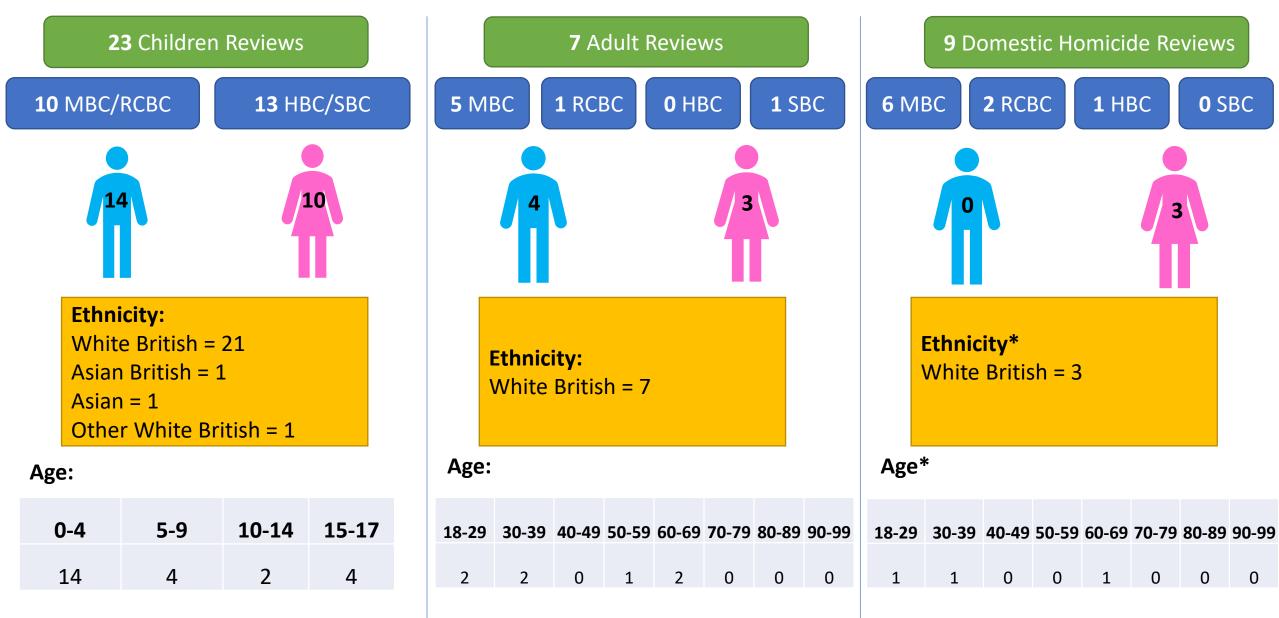
(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship

or

(b) a member of the same household as himself

held with a view to identifying the lessons to be learnt from the death.

Setting the Scene



Setting the Scene

7 Adult Reviews

Homelessness/Housing Issues (6)

Trauma / Traumatic Event (s) (5)

0 HBC

1 SBC

6 MBC

1 RCBC

Main Themes:

Self-Neglect (6)

Mental Capacity (5)

Substance Misuse (4)

Mental Health Issues (4)

Professional Curiosity (4)

Physical Abuse (4)

5 MBC

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9 Domestic Homicide Reviews

Multi-Agency Communication

Raising awareness of Domestic

Abuse /missed opportunities

Hidden victims – barriers to

Recognising/Escalating Risks

Lack of Professional Challenge

and Information Sharing

1 HBC

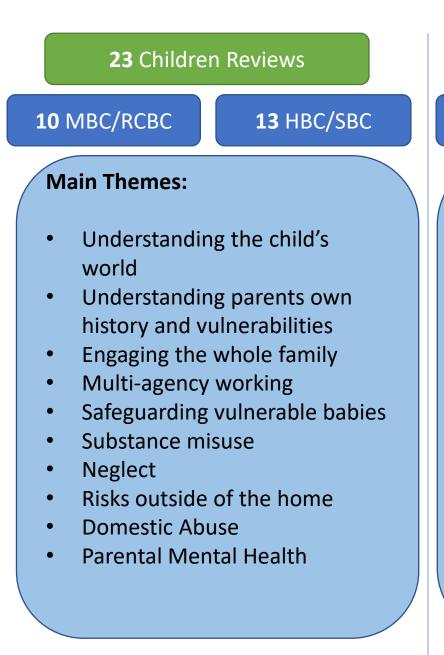
0 SBC

2 RCBC

Main Themes:

reporting

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Cross Over Themes

Information Sharing

Professional Curiosity

• Trauma