



Havering Partnerships' Case Review Working Group Terms of Reference

Date October 2023

Purpose

- To identify improvements to be made to safeguard and promote the welfare and wellbeing of children and adults with care or support needs in and from Havering as applicable, and to share and learn from good practice and multi-agency working;
- To quality assure and sign off Safeguarding Adults' Reviews, Learning or Child Safeguarding Practice Case Reviews for the Partnerships, ensuring that reviews should seek to prevent or reduce the risk of recurrence of similar incidents;
- To scrutinise Serious Incidents and Near Misses involving children and young people, adults and their families in Havering and decisions made about follow up actions thereof;
- To oversee actions and learning from the local and regional CDR processes (Child Death Review) and any other significant findings from published peer reviewed research and understand local and national Domestic Homicide Review findings;
- To consider learning from cases which involve a range of types of abuse of adults or children and ensure learning is then embedded in practice, including the overarching principle of Think Family;
- To oversee actions and learning from the local and national LeDeR (Learning Disability Mortality Review) processes, as well as the Drug Related Death Review Panel.

Where the Statutory Safeguarding Partners, or the SAB (Safeguarding Adults' Board) Chair decide that a case meets the criteria for a case review, to support the group, and oversee the agreed process for undertaking the review with the National Child Safeguarding Review Practice Panel;

- Receive and review data and significant information on allegations against staff and volunteers who work with children or adults;
- As part of the learning and improvement framework consider learning from a national basis to improve practice;
- Influence the development of training and workforce development needs to address the area of improvement raised in case reviews;
- Review cases referred by members of the Partnership where there have been interagency difficulties in working together to safeguard a child or adult (but does not meet case review criteria);



- To oversee multi-agency action plans to completion from case reviews.

The standing Case Review Working Group role

The standing Case Review Working Group will meet quarterly, with the agenda divided by adults and children to ensure good use of attendees' time. The Case Review Working Group for the area in which the child or adult is normally resident should decide whether an incident notified to them meets the criteria for a case review. This decision should normally be made within 15 working days of notification of the incident by means of a Review. For LB Havering children referred for a review, there are links with the Child Death Review processes. For Adults with learning disabilities who are/were residing in Havering at the time of the serious incident, there are links to the Learning from lives and deaths process (LeDeR), and for adults with drug and alcohol issues who die, there are links to the Drug Related Death Review Panel process.

A Review will involve all involved agencies providing information and / or chronologies and an emergency Working Group meeting being convened, unless the standing Working Group is taking place within a reasonable timescale to review the matter. The Working Group will collate information from involved agencies and provide an analysis of learning factors.

The Working Group will be involved in the decision making on whether a Review should be undertaken and the Chairs of the Group will convey the decision to the Statutory Partners and HSCP Chair or HSAB Chair as soon as possible after the meeting to discuss the case. The Statutory Partners then take the final decision or requests further information in order to take a decision in relation to children. The HSAB Chair makes the final decision in relation to adults. All recommendations will be made in writing. The Statutory Partners may wish to take advice from the HSCP Chair or the National Child Safeguarding Practice Review Panel. The HSCP will inform the National Child Safeguarding Practice Review Panel, (Department for Education) and Ofsted about their decisions.

If the Statutory Partners cannot agree, this is escalated to the HSCP Chair for a decision.

Locally, the HSCP or HSAB commissions and oversees the review of cases, accountable to the Working Group. The Working Group will have input into the suggested reviewers, and the Terms of Reference, and will have regular updates as to the progress of reviews. Draft reports will be taken to the Working Group for discussion prior to presentation to the Statutory Partners.

The Working Group will seek to have influence into national reviews which involve local cases, through oversight of the Terms of Reference and regular updates from the National Child Safeguarding Practice Review Panel.

For child safeguarding incidents, the Partnership has the duty to notify Ofsted and the National Panel.



Where a Local Authority or safeguarding children partner knows or suspects that a resident child or adult has been abused or neglected,

- If a resident child or adult with care or support needs dies or is seriously harmed in the local authority's area, or
- While resident in another area or country, the normally resident child or adult with care or support needs dies or is seriously harmed.

All agencies will share all these incidents with the Statutory Partners in the CCG (Clinical Commissioning Group) and Police.

For children, the decision makers will be the Statutory Partners- DCS (Director of Children's Services), Detective Superintendent of Police and the Associate Director for Safeguarding Children, NEL HCP

For adults, the decision maker for the Local Authority will be the DASS (Director of Adults' Services), depending on where the adult was ordinarily resident, supported by the Principal Social Worker, as agreed by the HSAB Statutory Partners. If the adult is/was resident in Havering, however had ordinary residence with another local authority, the DASS in that local authority will be consulted.

Children

In line with Chapter 4, Working Together 2018, partners must take into account the following criteria in determining whether to carry out a local Child Safeguarding Practice Review or request a review by the national Child Safeguarding Practice Review Panel:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf

Local Child Safeguarding Practice Review:

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 which the Child Safeguarding Practice Review Panel has considered and concluded a local review may be more appropriate;

-some cases may not meet the definition of a "serious child safeguarding case", but



National Child Safeguarding Practice Review:

The case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including when those improvements have been previously identified;
- raises or may raise issues requiring legislative change or changes to guidance issues under or further to any enactment;
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children;
- significant harm or death to a child educated otherwise than at school;
- where a child is seriously harmed or dies while in the care of the local authority, or while on (or recently removed from) a child protection plan;
- cases which involve a range of types of abuse;
- may raise issues relating to the safeguarding or promoting the welfare of children in institutional settings.

Adults

Safeguarding Adults' Reviews (SARS) are statutory reviews under Section 44, Care Act 2014, which stipulates that the Safeguarding Board (SAB) must arrange a SAR when an adult in its area with care and support needs (whether or not the local authority has been meeting any of those needs) dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. The SAB must also arrange a SAR if the adult has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB will seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

It is important to note that any agency can notify the SAB of a serious incident they think should be considered for a Safeguarding Adult Review (SAR). However, this process can also be used where cases do not meet these criteria but appear to offer an opportunity for learning in respect of multiagency working using alternative methodology – this will be known as a discretionary review. In all cases a Review will be undertaken to determine the most appropriate response.

A SAR can:

- look at any lessons that can be learnt from the case about the way professionals and agencies worked together;



- review the effectiveness of safeguarding adults' procedures;
- inform and improve practice;
- identify what can be done differently to avoid a similar circumstance from reoccurring.

Learning from Safeguarding Adult Reviews will be shared widely within local organisations and through the SAB website.

The following principles should be applied by Safeguarding Boards and their partner organisations to all reviews:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be Chaired/led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. SARs should reflect the six safeguarding principles.

The SAB should agree Terms of Reference (ToR) for any SAR they arrange and these should be published and openly available. When publishing SARs the records should be anonymised and (if applicable) redacted, or consent should be sought.

Early discussions need to take place with the adult, family and friends to agree how they wish to be involved. The adult who is the subject of any SAR does not need to be, or have been, in receipt of care and support services for the Safeguarding Board to arrange a review in relation to them.

Domestic Homicide Reviews

Part of the function of the Community Safety Partnership is

- To conduct reviews of domestic homicides as required by the Domestic Violence Crime and Victims Act 2004 and advise partners including the Office of the Police and Crime Commissioner (OPCC) on lessons learned

The standing CRWG will also be convened to consider potential domestic homicide deaths, including suicides, to provide multi-agency information in a timely manner so that a recommendation can be made to the Chair of the Community Safety Partnership, the Chief Executive of Havering Council.

Core Membership

Membership of the Working Group will consist of representatives from the following agencies or sectors:



- Co-Chairs
- Metropolitan Police Service Borough Command Unit;
- Children Services, Havering Council
- Adult Social Care, Havering Council
- Designated Nurses and Designated Doctors for Safeguarding, NEL Integrated Care Board
- NELFT NHS Trust (therapies, mental health and community nursing provider organisation in Havering)
- Havering Council Public Health
- Housing Department, Havering Council
- Community Safety Manager, Havering Council
- Lay Member
- CDOP Manager as required
- Barking, Havering, and Redbridge (BHRUT) NHS Foundation Trust
- Havering Education Services, Havering Council
- National Probation Service as required

Advisers to the Working Group:

- Local Authority Legal Department
- Partnership Manager.

Other partners will be requested to attend, as required, as visitors to the Group. Any other specialist advisers will also be invited, as required. They will be expected to follow the group's and their sector's confidentiality agreement. In situations where there is scrutiny of a particular agency case, to ensure independence, this will be presented by another member of staff, instead of the Group Chairs. Any conflicts of interest in decision making must be declared and will be scrutinised by the Independent Scrutineer, who will scrutinise the Partnership's management of serious incidents involving children, and the SAB Chair for issues related to adults.

Duties of Working Group Members:

- To represent their sector or agency as a Senior Leader, able to bring timely information to the meeting as required and contribute to decision making;
- Where an agency representative is not able to attend, they will identify an appropriate, consistent colleague as deputy representative to attend on their behalf;
- To raise alerts on serious incidents or near misses as known to their agency or sector;
- To support the Chairs, Statutory Partners and SAB Chair in scrutinising cases to determine if the criteria is met for a practice case review, independent of their agency or sector loyalty.

Standards of Conduct for Working Group Members:



- To maintain the confidentiality agreement signed on becoming an HSCP / SAB Member;
- To ensure documents and electronic information are stored, transported and communicated securely;
- To maintain the Nolan Principles of conduct in public life (see Appendix 1 below).

Governance

In deciding regarding a case review, the Chairs of the Working Group advise the Statutory Partners, who are the final decision maker in relation to children cases; they advise the SAB Chair in relation to adult cases. The Working Group will meet 4 times per annum and also at short notice when required. The Chairs will provide a Working Group update to the Partnerships quarterly, as required. Administration of CSPRs and SARS is carried out by the Partnership Team.

The Partnership principle is that of proportion, therefore only one decision meeting and one multi-agency review would be undertaken in relation to an incident or death, eg a DHR and not a SAR or CSPR at the same time.

At least 50% of agencies must be present for the meeting to be quorate, of which Health, Police and Children's and Adults' Social Care must be represented. The Review meeting must also be quorate.

Attendance at Working Group meetings will be monitored and information included in the HSAB, and HSCP's Annual Reports.

Meeting agendas and papers will be circulated at least seven working days before the meeting. Minutes will be distributed to the Working Group within three weeks of the meeting.

Review

The Terms of Reference will be reviewed annually and are agreed by Statutory Partners:

Detective Superintendent Lewis Basford, North East Command, Metropolitan Police
Korkor Ceasar, Assistant Director for Safeguarding Children, NEL ICB
Tara Geere, Director of Starting Well, Havering Council
Barbara Nicholls, Director of Adult Social Care & Health, Havering Council
Brian Boxall, Chair HSAB and HSCP

Date signed October 2023

Appendix 1

Nolan Principles of Conduct in Public Life

Selflessness



Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family or their friends.

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness

Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

Holders of public office should promote and support those principles by leadership and example.