7 Point Briefing –Learning Reviews

The Hull Collaborative Partnership have produced this 7 point briefing to inform partners of the different variations of learning reviews that take place across the partnership.

The aim of all reviews is to ensure learning is identified to improve our safeguarding response to children and adults across the whole safeguarding system. In Hull, we are committed to ensuring best possible practice through adopting a multi-agency approach and a culture of learning and driving forward activity to improve outcomes for children and adults.

1

What is a Domestic Abuse Related Deaths Review (DARDR)?

The Home Office confirmed that Domestic Homicide Reviews would be renamed to Domestic Abuse Related Death Reviews (DARDRs). The name change has been confirmed at Part 1 Section 19 of the Victims and Prisoners Act 2024. A DARDR is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from domestic abuse. A DARDR is a statutory requirement for all local agencies, and where possible involving the family or those closely connected to the victim, to work together to develop learning from the review which is then ratified by the Home Office. In advance of the Home Office ratification, we will share learning to all agencies at the earliest opportunity.

Victims and Prisoners Act 2024: Implementation of the duty to collaborate - GOV.UK

The Domestic Abuse Act 2021 (Commencement No. 6 and Saving Provisions) Regulations 2024

2

What is a Learning from lives and deaths - people with a learning disability and autistic people (LeDeR)?

LeDeR reviews are a service improvement programme funded by NHS England which aims to improve services for people with a learning disability and autistic people who are aged 18+. LeDeR shows that people with a learning disability and autistic people die earlier on average than other people, and do not always receive the same quality of care. Integrated care boards (ICB) are responsible for ensuring that LeDeR reviews are completed based on the health and social care received by people with a learning disability and autistic people who have died, using the standardised review process. This enables the integrated care systems to identify good practice and what has worked well, as well as where improvements in the provision of care could be made. Local actions are taken to address the issues identified in reviews. Recurrent themes and significant issues are identified and addressed at a more systematic level, regionally and nationally.

Report the death of someone with a learning disability or an autistic person

3

What is an Safeguarding Adult Review (SAR)?

Safeguarding Adults Reviews (SARs) are a statutory requirement for Safeguarding Adults Boards. Section 44 of the Care Act 2014 requires that a SAR is undertaken where an adult with care and support needs has died or suffered serious harm, and it is suspected or known that the cause was neglect or abuse.

Safeguarding adult practice can be improved by identifying what is helping and what is hindering safeguarding work, in order to tackle barriers to good practice and protect adults from harm. The process involves multi agency analysis and considering improvements across the whole safeguarding system to improve outcomes to adults where there are care and support needs.

4

What is a Line of Sight (LOS)?

The LOS process is a core function of the Hull Safeguarding Children Partnership (HSCP) and Adult Safeguarding Partnership Board. The process provides learning opportunities across the partnership to strengthen multi-agency working and focuses on improving outcomes for children, young people and adults.

The process identifies specific learning themes through audit and multi-agency analysis. Learning is implemented across the partnership to improve practice across the safeguarding system.

The Care Act 2014 (sec44) and Working Together 2023 give Safeguarding Children Partnerships and Adult Safeguarding Boards flexibility to undertake discretionary learning where criteria for a full LCSPR or SAB is not met, however learning would be beneficial to strengthen multi agency safeguarding practice.

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5

What is a Child Safeguarding Practice Review?

As outlined in Working Together 2023 a **Local Child Safeguarding Practice Reviews (LCSPRs)** are conducted when a child has been abused or neglected (known or suspected), resulting in serious harm or death. The purpose of these reviews is to bring about changes that improve the practice system for children and families and reduce child abuse and neglect. Following a serious safeguarding incident, local safeguarding partners submit a rapid review to the Child Safeguarding Practice Review Panel in England

What is a Rapid Review?

Guidance for rapid reviews is outlined in Working Together to Safeguard Children (2023) and the Child Safeguarding Practice Review Panel published guidance. Safeguarding partners are required to promptly undertake a rapid review on all notified serious incidents – *'Abuse or neglect of a child is known or suspected, and the child has died or been seriously harmed'.* Rapid Review are required to take place within 15 working days of notification to National Panel.

National Child Safeguarding Practice Reviews are conducted when a child dies or is seriously harmed due to abuse or neglect. The reviews aim to identify how local professionals and organisations can improve their safeguarding practices. Criteria for national learning reviews are identified as national significance.

6

What are child death reviews (CDR)?

As set out in the Children Act 2004 and amended by the Children and Social Work Act 2017, Local Authorities and Integrated care boards in England, form the Child Death Review partners, and have a statutory responsibility to make arrangements to ensure all deaths of children normally resident in the local area and, as indicated, of any non-resident children who have died in their area, are reviewed through the child death review process.

The child death review process includes multiple multiagency processes that are initiated when a child dies including notifications, immediate decision making and information gathering, and child death review meetings, culminating in formal review by the Child Death Overview Panel. The CDR process is firmly rooted in deep respect for families and is focussed on learning and understanding why children die. The CDR process also has multiple interfaces with other statutory and non-statutory review processes for children, and CDOP would typically not conclude the review until all other review processes had concluded.

7

Where can I find local reviews that have already taken place?

- Domestic homicide reviews – Hull Collaborative Partnership
- HSAPB - Safeguarding Adults Reviews – Hull Collaborative Partnership
- Line-of-Sight Local Learning Reviews – Hull Collaborative Partnership
- NHS England » Publication Containers

Additional links and resources

- Recently published case reviews | NSPCC Learning
- Child Death Review Statutory and Operational Guidance (England)
- Safeguarding Adults Reviews (SARs) - SCIE
- NHS England » Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)
- Draft DHR statutory guidance
- Child Safeguarding Practice Review Panel guidance for safeguarding partners
- The Collaborative Partnership – Hull Collaborative Partnership
- Child Safeguarding Practice Review Panel - GOV.UK
- National review into the murders of Arthur Labinjo-Hughes and Star Hobson - GOV.UK