Safeguarding Children in Brent

Brent Safeguarding Children Partnership

Annual Report

October 2019 - October 2020

Brent | NHS Brent Clinical Commissioning Group | Metropolitan Police

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1. Introduction

1.1. From September 2019, the Children's and Social Work Act, 2017 passed responsibility for safeguarding children in a local authority area to the council, police and health providers/ commissioners. In Brent, these three statutory partners have formed an Executive Group. Section 2.1 to 2.11 gives more information about our roles and responsibilities. This is our first annual report.

1.2. We recognised that the Local Safeguarding Children Board (LSCB), had developed excellent working relationships with numerous partner agencies. The new Safeguarding Children Forum builds upon these links and ensures engagement at an operational level. Section 2.12 to 2.24 outlines the responsibilities and expectations of Forum members who represent Brent services (e.g., local schools), those working across borough boundaries (e.g., health providers) or London wide (London Ambulance Service). It is good to have two residents, with a particular interest in safeguarding in Brent, as members.

1.3. The legislation introduced new requirements for managing Serious Case Reviews (SCRs); shown in section 3.1 to 3.6. There is a new definition of a 'serious safeguarding event', a requirement to notify the Child Safeguarding Practice Review Panel (commonly known as the 'National Panel') within 5 working days and a stipulation that a Rapid Review meeting must be convened within 15 working days of the notification.

1.4. These deadlines, plus a SCR commissioned prior to the dissolution of the LSCB, meant that case reviews have taken priority. The remaining paragraphs in section 3 explain the notification process, the conduct of each Rapid Review and, most importantly, summarises the learning and recommendations from each case. The Panel assess our conclusions from each review. In every submission, it has agreed with our decisions.

1.5. In this report, we have highlighted two particular cases as evidence of our meticulous and rigorous approach to these reviews.

1.6. One involves a challenge from us to the Panel regarding a statutory agency's safeguarding guidance to their staff and its application in their decision making, and a second which recognised exemplary practices by a number of agencies responding to an attempted suicide.

1.7. Cases such as these, can be both stressful and traumatic for staff who respond to the initial incident or subsequently care for the injured/ traumatised child. Where appropriate, we have encouraged other senior colleagues to assure themselves that their staff are offered counselling or other suitable interventions.

1.8. We continue to evaluate all aspects of our response to rapid reviews. The increasing number prompted a re-evaluation of our internal processes. We concluded that our systems needed more structure and clarity, as outlined in section 3.19 to 3.29. This work is now under consideration by NHS England as best practice.

1.9. The demands necessitated by the volume of rapid reviews (12 between April 2019 and October 2020) plus the impact of COVID-19 on everyone's workload, staffing and priorities, triggered a complete overhaul of our proposed work schedule.

1.10. The domestic abuse, neglect and exploitation priority groups were disbanded. The Case Review Group, responsible for the Rapid Reviews and subsequent action plans, now meets more frequently. Plans to use the results from the 2019 section 11 audit questionnaire have been put on hold, and the independent scrutiny arrangements are still under consideration.

1.11. Yet we are confident about the safeguarding arrangements for Brent's children thanks to the Rapid Review process. Lord Laming famously wrote that "Safeguarding is everyone's business". The attendance and participation of a variety of organisations at Rapid Review meetings as shown in paragraph 3.24, evidences this quote in Brent.

1.12. Learning is spread across organisations as shown in Appendices C and D. One finding from a Rapid Review has informed a re-vamped multi-agency domestic abuse virtual training session.

1.13. Cases have highlighted good practice in areas such as domestic abuse and neglect. Independence is provided by the many professionals from different backgrounds who attend the meetings and provide insight and experience.

1.14. Despite all the difficulties posed by COVID-19 and the unforeseen nature and complexity of the workload, we thank everyone for their continuing dedication and commitment. We are assured that our safeguarding arrangements are effective and robust.

2. Safeguarding children arrangements in Brent

2.1. The Brent safeguarding partnership arrangements began to operate in September 2019 and replaced the previous Local Safeguarding Children Board arrangements.

2.2. The new partnership arrangements follow the introduction of the Children and Social Work Act in 2017 and the publication of the revised statutory guidance Working Together 2018; both of which set out what is expected of organisations, individually and jointly, to safeguard and promote the welfare of children.

2.3. Brent's arrangements have been designed to capitalise on the pre-existing engagement of a range of partner agencies and momentum developed by the Independent Chair of Brent LSCB.

2.4. The arrangements also aim to reflect the national legislative changes and the statutory leadership roles of the three safeguarding partners – local authorities, clinical commissioning groups and police.

2.5. The arrangements consist of a two-tier structure with the Executive Group providing high-level strategic direction to a delivery focused Brent Safeguarding Children Forum made up of a diverse and wide-ranging partnership.

2.6. Further details of the Brent Safeguarding arrangements can be found on the new Brent Safeguarding Partnerships website.

Brent Statutory Safeguarding Partners Executive Group

2.7. The Executive Group fulfil the objectives, functions and responsibilities set out in Working Together 2018 to safeguard and promote the welfare of all children in Brent by;

- agreeing the overarching strategic vision and local priorities for safeguarding children
- challenging and holding the Safeguarding Forum to account
- agreeing, publishing and reviewing the safeguarding oversight arrangements
- monitoring serious child safeguarding cases which raise issues of importance
- ensuring that the arrangements to work together to identify and respond to the needs of children in the area are effective and robust
- identifying any new safeguarding issues and emerging threats

2.8. The Executive Group membership includes:

Brent Council	Chief Executive
	Strategic Director of Children and Young People
	The Leader and Statutory Lead Member for Children's Services (Safeguarding, Early Help and Social Care)[1]
Brent CCG / North West London collaboration of CCGs	Director of Quality, Nursing and Safeguarding
Metropolitan Police	Head of Safeguarding, North West Basic Command Unit
Independent Convener for Brent Safeguarding Children Forum	

2.9. The Executive Group was set up in December 2017 to develop and agree the local arrangements. Since December 2017, the Executive Group has met a total of 12 times. Between 1 October 2019 and 1 October 2020, the Executive Group met four times (October 2019, February 2020, May 2020 and July 2020).

2.10. All three partners share the responsibility to plan and chair the meetings on a rotational basis.

2.11. The Executive Group consider the findings from rapid reviews and where appropriate have questioned some of the partnership working arrangements. These are referred to in section 3. Examples of this are:

- The Brent Council Chief Executive Officer challenging the CPS regarding the application of their safeguarding policies (Case Study Child A).
- NWL CCG Director of seeking reassurance from the Case Review Group around partnership working in responding to domestic abuse in Brent.
- Metropolitan Police intervening with the Coroner's Office to expedite into a child death which is over 2 years old and still awaits an inquest.

[1] The Leader of Brent Council and the Statutory Lead for Children's Services (Safeguarding, Early Help and Social Care) are politically accountable for ensuring the local authority fulfils its legal responsibilities for safeguarding and promoting the welfare of children. They provide the political leadership needed for the effective co-ordination of work with other agencies who have safeguarding responsibilities and therefore are also members of the Executive Group.

Brent Safeguarding Children Forum

2.12. The Brent Safeguarding Children Forum is a wider partnership forum accountable to the Executive Group.

2.13. The Forum co-ordinates and monitors multi-agency safeguarding oversight arrangements as set out in Working Together 2018 and is led by an Independent Convenor.

2.14. The Forum is responsible for;

- driving delivery of local safeguarding priorities set by the Executive Group
- building relationships with other strategic partnerships, the local community, and schools and other educational establishments
- seeking assurance on behalf of the Executive Group that partners are fulfilling their safeguarding responsibilities, sharing information effectively and have robust safeguarding policies and procedures in place through multi-agency audits (including S.11 audit) and Forum meetings
- continuing to follow the London Child Protection Procedures and develop and maintain a Brent thresholds document
- developing, implementing and monitoring the impact of an interagency safeguarding children learning and development offer, incorporating local and national learning from serious child safeguarding cases
- analysing and considering partnership responses to any new safeguarding issues and emerging threats identified by the Executive Group
- undertaking Local Learning Reviews on behalf of the Executive Group
- developing ways for the safeguarding oversight arrangements to include the voices of children and families in Brent

2.15. The Safeguarding Partners selected the agencies and organisations drawn from a list of 'relevant agencies' set out in Working Together 2018. These agencies and organisations have been chosen as they provide key strategic and operational insight to the safeguarding children and young people in Brent.

2.16. The selected relevant agencies form the core membership of the Brent Safeguarding Children Forum.

2.17. Forum members are expected to;

- proactively and enthusiastically engage with the partnership safeguarding arrangements
- be able to influence the strategic planning for safeguarding children within their agency
- be able to secure appropriate information from their agency to support the partnership work
- ensure that decisions of the Forum are taken forward within their own agency, and any impediments or delays to their implementation are reported to the Board
- be responsible for communicating the partnership work effectively within their agency

2.18. The Safeguarding Partners recognise the importance of involving the local community and agreed to retain the existing lay members who were part of the previous LSCB arrangements. Two of the five LSCB lay members continued as members of the Safeguarding Children Forum.

2.19. The lay members continue to act as valuable ambassadors to help build stronger links with the local community as part of the new arrangements and are encouraged to:

- promote awareness of safeguarding across Brent's communities
- represent the community voice at Safeguarding Forum meetings
- engage with Brent's people and local groups to support community cohesion

2.20. The Forum continues to develop and strengthen the existing engagement from early years, schools and the Further Education College in the borough and has a significant membership from this sector.

2.21. The membership of the Forum includes representation from the following partners, relevant agencies and organisations;

Safeguarding partners	
Brent CCG	Designated Professionals Named GP for Safeguarding
Brent Council	Children and Young People Housing Needs Safeguarding Adults Public Health Community Safety
Metropolitan Police	North West Borough Command Unit (BCU) Safeguarding

Agency/organisation	
Barnardos (Children's Centre provider service)	
Central London Community Healthcare Trust	
Central North West London Mental Health Foundation Trust	
Children and Family Court Advisory and Support Service (CAFCASS)	
Community Rehabilitation Company (CRC)	
Education establishments	College of North West London/ United Colleges Group Capital City Academy Newman Catholic College Stonebridge Primary School The Village and Woodfield Special Schools
London Ambulance Service	
London North West University Healthcare NHS Trust	
National Probation Service	
Queens Park Rangers Football Club	
Two lay members	

2.22. Attendance at all Safeguarding Forum meetings is monitored and where any concerns arise regarding attendance and engagement of relevant agencies, the Independent Convener raise these with both the agency concerned and the Executive Group.

2.23. During the first year of the new safeguarding partnership arrangements the partnership and agency attendance at Forum meetings has been exemplary and no concerns have been raised.

2.24. The Safeguarding Forum normally meets 5 times a year, between 1 October 2019 and 1 October 2020 the Forum met four times (December 2019, February 2020, June 2020 and September 2020). The meeting scheduled for April 2020 was cancelled due to the impact of the Covid-19 pandemic.

Case Review Group

2.25. The Case Review Group is critical to the work of the Safeguarding Partners in Brent. It is the key mechanism for carrying out reviews of cases that meet the criteria set out in Working Together 2018 for a serious safeguarding Incident (for more details see Section 3 - Local Child Safeguarding Practice Reviews in Brent).

2.26. The Case Review Group meeting is chaired by the Independent Convenor and is responsible for:

- carrying out rapid reviews for all serious incident cases (that meet the criteria) in Brent and making recommendations to the Safeguarding Partners for determination if the learning review criteria has been met
- identifying recommendations for any lessons to be learnt from serious incidents in Brent
- coordinating the arrangements on behalf of the safeguarding partners for commissioning and publishing local child safeguarding practice reviews
- developing the terms of reference, monitoring progress developing improvement plans coming for each local review
- making recommendations for multi-agency learning events based on the findings arising from case reviews and what the process is for undertaking them
- sharing examples of good practice to develop understanding of what works well
- monitor and intervene, where appropriate, in other safeguarding areas' reviews that involve Brent services

2.27. The Case Review Group has a fixed core membership drawn from the statutory safeguarding partners and relevant agencies. It has the flexibility to invite other relevant professionals to discuss certain cases as and when appropriate (including rapid reviews).

2.28. The core membership of the Case Review Group includes representation from the following partners, relevant agencies and organisations;

Safeguarding partners	
Brent CCG	Designated Professionals Named GP for Safeguarding
Brent Council	Children and Young People Community Safety Legal
Metropolitan Police	North West Borough Command Unit (BCU) Safeguarding
Agency/organisation	
Central London Community Healthcare Trust	
Central North West London Mental Health Foundation Trust	
London North West University Healthcare NHS Trust	

2.29. In recognition of the sensitive and confidential nature of business all agency representatives/members must sign a confidentiality agreement which includes the requirement to appropriately share and securely store information.

2.30. The Case Review Group ensures that where possible and appropriate to do so, children, young people and families are involved in local child safeguarding practice reviews/serious case reviews. For example, dialogue with the parents of Child K as part of the serious case review mentioned in section 3 of this report.

2.31. The Case Review Group maintains links with the NWL Child Death Review Child process and ongoing considerations take place about linking review processes locally where child deaths are considered as part of both processes.

2.32. During the period covered in this report, the Case Review Group met 5 times (November 2019, January 2020, June 2020, July 2020 and October 2020). The meeting scheduled to take place in April 2020 was postponed to June 2020 due to the impact of the Covid-19 pandemic.

2.33. Details on the work of the Case Review Group during this period are in Section 3 of this report.

Learning & Development Advisory Group

2.34. The Learning and Development Advisory Group is part of the Safeguarding Partnership arrangements.

2.35. The group is co-chaired by Pam Stewart, Lay Member and Rachel Phillips, Named Nurse for Safeguarding Children, Central London Community Healthcare NHS Trust.

2.36. The part time Strategic Partnerships Learning and Development Co-ordinator supports the co-chairs in coordinating the Learning and Development Advisory Group.

2.37. The functions of the Learning and Development Advisory Group are to:

- promote multi-agency learning from local and national learning reviews and audits
- promote multi-agency learning from safeguarding best practice
- promote multi-agency learning around identified local and national priorities
- provide updates on the progress and the impact of the multi-agency learning programme
- provide recommendations and suggested actions to improve multi-agency practice through learning and development in Brent

2.38. The membership of the Learning and Development Advisory Group includes representation from the following partners, relevant agencies and organisations;

Safeguarding partners	
Brent CCG	Designated Professionals Named GP for Safeguarding
Brent Council	Children and Young People Community & Wellbeing
Metropolitan Police	North West Borough Command Unit (BCU) Safeguarding
Agency/organisation	
Central London Community Healthcare Trust	
Central North West London Mental Health Foundation Trust	
London North West University Healthcare NHS Trust	
2 lay members	

2.39. During the period covered in this report, the Learning and Development Advisory Group met 3 times (January 2020, July 2020 and October 2020).

2.40. Details on the multi-agency learning and development programme offered during this period are in Section 4 – Multiagency Learning and Development.

Support arrangements

2.41. Support staffing arrangements for the Brent safeguarding children partnership arrangements are funded and resourced by Brent Council.

2.42. The Strategic Partnerships Team lead the coordination of the arrangements and have the following staff/resources within the team;

- A full time Strategic Partnerships Lead (who also supports the Brent Children's Trust)
- A part time Strategic Partnerships Learning and Development Coordinator (who also supports Safeguarding Adults Board).

2.43. Alongside the safeguarding children partnership arrangements, the Strategic Partnerships Team also coordinates activities for other strategic partnerships in Brent including;

- Brent Safeguarding Adults Board
- Brent Health and Wellbeing Board
- Brent Children's Trust

2.44. This arrangement allows stronger strategic coordination between the strategic partnerships in Brent to both avoid duplication and develop joint initiatives. It also facilitates a level of independence from operational activity.

2.45. The Brent Council Governance Team provide administration support for the delivery of Executive Group and Safeguarding Forum meetings.

Independent Convenor

2.46. The Safeguarding Partners agreed that the Safeguarding Forum will be led by an Independent Convenor.

2.47. The independent scrutiny function as set out in Working Together 2018 provides the critical challenge and appraisal of Brent's safeguarding partnership arrangements.

2.48. It was also agreed that the Independent Convenor would undertake the role of the Independent Scrutineer.

2.49. The volume and complexity of rapid reviews has precluded a structured programme of audit/scrutiny. However, the more recent rapid reviews have demonstrated good practice in areas such as domestic abuse and the provision of Tier 4 mental health services. Therefore, such in depth analysis, drawing upon a wide range of agencies participating in rapid reviews provides assurance to the Strategic Partners that the multi-agency arrangements are working effectively to safeguarding our children.

2.50. Another area of assurance arising from the rapid reviews is that there is an increased attendance and engagement of a variety of local and national agencies who in the past may not have had safeguarding at the forefront of their operational activity, examples include the British Transport Police and the Border Force.

Financial arrangements

2.51. The safeguarding partners agreed the funding secured from each partner and contributions from each relevant agency, to support the local arrangements.

2.52. The annual contributions to the safeguarding partnership arrangements for 2019/2020 remained the same as the previous LSCB funding.

2.53. The financial year runs from the 1 April to the 31 March the following year, with contributing agencies being invoiced by the 1st October each year (where possible).

2.54. It is important to note that whilst Working Together 2018 states the funding from each partner 'should be equitable and proportionate' this is not so in Brent. Despite lobbying by the Strategic Partners, all London boroughs, regardless of size, continue to receive the same level of financial contribution from the Metropolitan Police which is agreed centrally and set at £5,000.

2.55. Following consultation at a national level, CAFCASS made the decision to remove the financial contributions previously made to LSCBs (in Brent this was £550 per annum).

2.56. From April 2019 to March 2020, the funding arrangements for the safeguarding partnership totalled £174,000. The breakdown of this total amount is shown in the table below:

Safeguarding Partnership funding contributions 1 April 2019 - 31 March 2020	
Partner Organisation	**Amount (£)**
Brent Council (staffing costs)*	110,000
Brent CCG	45,900
London North West University Healthcare NHS Trust	11,000
MOPAC/Met Police	5,000
London Fire Brigade	500
National Probation Service	1,600
Total contributions	**174,000**

* The support staffing arrangements funded by Brent Council include:

- 1 full time Strategic Partnerships Lead (also supports Brent Children's Trust)
- 1/2 part time Strategic Partnerships Learning and Development Coordinator (also support Safeguarding Adults Board)
- Portion of 1 full time Strategic Partnerships Manager
- Portion of Governance Team administration support for Executive Group and Safeguarding Forum meetings

2.57. The income and expenditure are managed and monitored by the Strategic Partnerships Team on behalf of the Executive Group.

2.58. The table below outlines the expenditure of the safeguarding arrangements during the 2019-2020 financial year:

Expenditure 1 April 2019 to 31 March 2020		
Expense		**Amount (£)**
Brent Council support staffing*		110,000
Independent Convener		28,000
Learning and Development	Venue and resource	970
	Closing costs for old online LSCB learning and development management system	5,400
	New online multi-agency learning and development management system set up	5,320
	External facilitator	985
Partnership meeting and resourcing costs		850
Strategic Partnerships joint website development		950
S11 Audit		4,375
Serious Case Review (committed £17,150)		7,150
Total expenditure		**164,000**

2.59. The remaining £10,000 from the contributions has been committed to the total cost of the Serious Case Review which will be concluded in year 2020/2021.

2.60. The funding contributions for Brent's Safeguarding Children Partnership arrangement for 2020/21 were confirmed in October 2020:

Confirmed funding arrangements for 2020/2021	
Brent Council (Strategic Partnerships Team staffing costs)	£127,000
Brent CCG/NWL CCGs	£45,900
MOPAC/Police	£5,000
National Probation Service	£1,600
London North West University Healthcare Trust	£11,000
Total contributions	**£191,000**

Working in partnership

2.61. The Safeguarding Partners recognise that there is potential cross over in some areas of work and priorities with other strategic partnerships in Brent.

2.62. During 2019/2020, the safeguarding partners continued to strengthen the existing links and align activity with other Brent partnerships (including the Brent Safeguarding Adults Board, Brent Children's Trust and the Safer Brent Partnership).

2.63. This co-operation has continued to allow the opportunity for other strategic partnerships to consider the progress of the safeguarding children arrangements and contribute to the identification of local safeguarding priorities.

2.64. To support this, the Independent Convenor attends the Brent Children's Trust and Safer Brent Partnership as a standing member.

2.65. The Safeguarding Partners continued to seek opportunities to develop joint areas of work. During the period, the partnerships developed a joint strategic workshop to explore the issue of transitional safeguarding and how it can be addressed in Brent (further details on this work can be found in section 4 of this report).

2.66. The Safeguarding Adults Board introduced an Executive Group utilising the model for the Children's Executive Group.

2.67. Discussions took place between the Independent Convener and the Head of Community Safety, Brent Council regarding the implementation of recommendations involving safeguarding children arising out of Domestic Homicide Reviews (DHR). To ensure that any further reviews, with a safeguarding children involvement, has an input from the Case Review Group at the earliest stage, the Deputy Community Safety Manager is now a standing member of the Case Review Group.

2.68. The aim of this change is to allow any remedial action to be swiftly implemented prior to the publication of the review.

2.69. The progress of Brent DHRs is also now an agenda item at all Case Review Group meetings.

3. Rapid Review Activity

Local Child Safeguarding Practice Reviews in Brent[2]

3.1. The main focus of activity for the partnership during 2019-2020 has been the work around local serious child safeguarding cases (as mentioned in Section 1– Introduction).

3.2. Following significant changes to the statutory framework for Serious Case Reviews (SCRs), revised statutory guidance[3] which was published in 2018 sets out the current arrangements for handling serious child safeguarding cases.

3.3. The purpose of these new arrangements is to identify improvements to be made to safeguard and promote the welfare of children both at a local and national level. It has been recognised that whilst local learning is relevant, it also has a wider importance for all practitioners working with children and families and for the government and policy-makers.

3.4. The responsibility for how the system learns the lessons from serious child safeguarding incidents lies;

- at a national level with the Child Safeguarding Practice Review Panel and
- at local level with the Brent Safeguarding Partners

Identifying a serious child safeguarding incident & Rapid Reviews

3.5. When the local authority becomes of any serious event that meets the criteria set out in Working Together 2018, it must notify the Child Safeguarding Practice Review Panel within 5 working days.

The criteria set out in Working Together 2018 states that:

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.***

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.*

[2] This section covers the period of activity relating to Rapid Reviews and Local Safeguarding Practice Reviews between April 2019 and October 2020.

[3] Chapter 4: Improving child protection and safeguarding practice of Working Together 2018
Child Safeguarding Practice Review Panel: practice guidance (April 2018)

3.6. When it has been determined that a serious safeguarding incident has taken place, Brent Safeguarding Partners must undertake a Rapid Review of the case. This must be completed within fifteen working days of becoming aware of the incident.

The aim of a Rapid Review is 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 to commission a Local Safeguarding Practice Review*

The process in Brent

3.7. The Brent Safeguarding Partners have made arrangements and published an agreed local procedure to identify and review serious child safeguarding cases in Brent. This procedure has been published on the Brent Safeguarding Partnerships website and can be accessed by clicking on the following link: Brent Safeguarding Partnerships website.

3.8. The Case Review Group (chaired by the Safeguarding Forum Independent Convener and coordinated by the Brent Council Strategic Partnerships Lead for Safeguarding Children) is the key mechanism agreed by the Brent Safeguarding Partners that carries out Rapid Reviews and local child safeguarding practice reviews in Brent (See Section 2 for more information on the Case Review Group).

3.9. The Brent Case Review Group continuously evaluates the local procedures for identifying and reviewing serious child safeguarding cases. As part of the ongoing evaluation of the local process, the Case Review Group agreed in November 2019 that when a serious incident occurs in Brent, the three safeguarding partner representatives4 will immediately jointly consider whether the circumstances known about the incident meet the serious child safeguarding case criteria highlighted above (paragraph 3.5).

3.10. This joint consideration then informs the final Brent Council decision to notify the Child Safeguarding Practice Review Panel of the incident.

3.11. In July 2020, the Case Review Group undertook a piece of work to revisit the decision making for all the cases that had been considered to meet the criteria for a notification to the Child Safeguarding Practice Review Panel with a view to improving the identification process (further detail on the findings of this work are documented under the evaluation of identifying a serious child safeguarding incident in Brent section below).

4 Brent CYP Head of Safeguarding & Quality Assurance, Metropolitan Police North West BCU DCI for Safeguarding and Brent CCG Designated Safeguarding Professionals

3.12. In January 2020, the Brent Case Review Group agreed to introduce the Brent Rapid Review Initial Scoping and Information Sharing template (see Appendix B). This information gathering template is designed to be circulated to all organisations known to be involved ahead of the Rapid Review meeting to allow the focus of the meeting to be on analysing and identifying learning rather than a chronology of events.

Brent Rapid Reviews follow a consistent structure which considers;

- The relevant identifying details of the child and family and a summary of the facts, so far as they can be ascertained, about the serious incident
- The immediate actions taken/needed of any children involved to ensure their safety (where appropriate)
- A review of the collated multi-agency scoping information submitted by all agencies known to be involved
- Improvements to systems and practice to safeguard and promote the welfare of children
- Any local and national multi-agency good practice as well as learning
- Whether the criteria for a local child safeguarding practice review have been met including a rationale for the decision
- The next steps in the process including progressing any identified learning.

3.13. Following the Rapid Review meeting, a record is drafted and shared with all present at the Rapid Review for comment and agreement.

3.14. The Independent Convener, on behalf of the Case Review Group, submits the Rapid Review record and findings to the Brent Safeguarding Partners for consideration and approval.

3.15. The final Rapid Review record is submitted to the Child Safeguarding Practice Review Panel for endorsement.

3.16. All local learning, recommendations and improvements are developed into action plans for implementation. The progress against these action plans is regularly monitored by the Case Review Group.

3.17. The Learning and Development Advisory Group support the Case Review Group to consider the best way to disseminate local learning to the widest possible audience.

3.18. The summarised case study below demonstrates the effectiveness of Brent's Rapid Review process.

Rapid Review Process - Case Study

Brent Council notified the Child Safeguarding Practice Review Panel of a serious safeguarding incident involving Child A, a five-year-old boy who was admitted to hospital with severe multiple injuries indicative of physical and sexual assault/abuse. Mother and her partner were arrested on suspicion of inflicting injuries to the child.

Rapid Review

In preparation for the Rapid Review into this case:

- Another London borough was invited to join the Rapid Review meeting as mother and child had recently moved into Brent.
- Good practice templates to gather initial scoping information from agencies known to be involved were shared with and adopted by Brent as a standard part of the Rapid Review process (see Appendix B).
- All agencies involved completed the initial information scoping template and the information was collated and shared with all participants ahead of the Rapid Review meeting. This enabled the meeting to comprehensively focus on key multi-agency practice episodes to identify both good practice and learning.

The Rapid Review of the case took place within 15 working days of the incident in line with Working Together 2018 guidelines and was chaired by the Independent Convener of Brent Safeguarding Forum who also chairs the Case Review Group.

The Rapid Review meeting was well attended by all the key agencies from both Brent and another London borough. There agencies included:

- Designated Professionals for safeguarding children (Clinical Commissioning Groups) from 2 boroughs
- Children and Young People services from 2 local authorities
- Central North West London Mental Health Trust (CNWL)
- 0-19 Service from 2 boroughs
- 2 Hospital Trusts
- Metropolitan Police (representation from the local BCU and from the Serious Crime Review Group)
- Primary School (located in another borough)

The meeting lasted 3 hours and the circumstances leading to the incident, the agencies' individual and collective responses were discussed, analysed and considered by all present. It was agreed that the Rapid Review was rigorous enough to identify learning, some of which has already been acted upon, to obviate the need for any further joint review.

As part of the Rapid Review, Brent identified a particular concern regarding the Crown Prosecution Service (CPS) safeguarding children guidance in this case and asked the Child Safeguarding Practice Review Panel (CSPR) to raise the concern through the CPS and Department of Justice.

The CSPR's initial response was challenged by Brent Council which resulted in their agreement to pursue concerns about CPS training and guidance with the CPS.

The CSPR Panel raised this concern with the Head of Policy at the CPS and identified issues which appeared to arise from the application of the guidance rather than the guidance itself. Brent Council further raised the concerns about the application of the CPS guidance in this case with the Director of Public Prosecutions and the Metropolitan Police Commissioner.

Following our intervention, we were reassured by the CPS response. The alleged perpetrators have been charged and have appeared in court.

Between April 2019 and October 2020, a total of 12 events occurred in Brent that potentially met the criteria laid out in Working Together 2018 as serious child safeguarding incidents

- 10 of the 12 events were deemed at the time to meet the criteria of a serious child safeguarding incident and subsequent notifications were made to the CSPR Panel.

- 10 Rapid Reviews were carried out by the Case Review Group to determine whether these serious safeguarding incidents met the criteria to conduct a Local Safeguarding Practice Review (or Serious Case Review under the previous LSCB arrangements).

- 4 of the 10 Rapid Reviews were carried out under the previous Brent LSCB arrangements to determine if the serious safeguarding incidents met the criteria to conduct a Serious Case Review (between 1 April 2019 and 21 September 2019).

- It was agreed that one of the Rapid Reviews conducted under the LSCB arrangements met the criteria for Serious Case Review (Child K) to be conducted.

- From March 2020, the Case Review Group began to conduct all Rapid Reviews (cases 8, 9 and 10) were conducted virtually through virtual meetings due to the Covid-19 Pandemic.

- All 10 Rapid Review decisions were endorsed by the CSPR Panel.

- The volume of Rapid Reviews has resulted in a significant amount of learning for all agencies. It is encouraging to note that the learning in earlier Rapid Reviews has resulted in improvements in practice which has been commented on in later Rapid Reviews.

Evaluation of identifying a serious child safeguarding incident in Brent

3.19. In July 2020, prompted by incident 8 and as part of the continuous evaluation of the Brent case review process, the Case Review Group reflected upon the local decision making of incidents that meet the criteria for a serious safeguarding incident and notification to the CSPR Panel.

3.20. The Case Review Group analysed the incidents that Brent had considered to be serious safeguarding cases between April 2019 and June 2020 (10 incidents). Analysis of these incidents revealed that:

Incident	Notification criteria met	Notification made
1	Yes	Yes
2	No	Yes
3	Marginal	Yes
4	Yes	Yes
5	No	**No**
6	Marginal	Yes
7	Yes	Yes
8	No	Yes
9	Yes	Yes
10	Marginal	Yes

- 1 out of the 10 incidents was not deemed to meet the criteria of a serious child safeguarding and did not result in a notification being made.

- 2 other incidents did not meet the criteria of a serious child safeguarding incident; however, these incidents however did result in notifications being made.

- It was debatable whether or not another 3 of the 10 incidents met the criteria, due to there being differing interpretations of the definition of abuse/neglect. All 3 of these cases did result in a notification being made.

3.21. As a result of this analysis, a fact finding/screening exercise was introduced in order to:

- allow the safeguarding partners to fully research the initial facts surrounding the incident
- better inform decision making on whether the criteria for a Serious Child Safeguarding Incident is met
- allow the safeguarding partners to jointly discuss the incident

3.22. A pro-forma was developed to document this fact-finding process (see Appendix A). Following the introduction of the pro-forma in July 2020, a further 2 potential serious child safeguarding incidents took place, the pro-forma was utilised and decisions were made jointly.

3.23. Feedback on the addition of the pro-forma has been positive, it is pleasing to note that it was discussed at the October 2020 London designated professionals meeting which was attended by Kenny Gibson, NHS England and NHS Improvement Board. It is being considered by for inclusion in the London easy read rapid review process document as good practice.

3.24. All the Rapid Review meetings (both face to face and virtually) have been very well attended, with significant participation from not only standing members but also those agencies with specialist knowledge of the case such as: Border Force, British Transport Police, Marie Stopes and Metropolitan Police Homicide Investigators. Their insight and contribution greatly assist the Case Review Group's decision-making processes.

3.25. The Case Review Group and Brent Safeguarding Partners (both individually and collectively) agree that the improvements that have been made to the Rapid Review process in Brent are working very well and valued locally.

3.26. Next steps have been identified to begin consideration of how to align this process with other review processes (such as Child Death Reviews, Domestic Homicide Reviews and Safeguarding Adult Reviews) as much as possible to avoid duplication. A representative of the Community Safety team is now a standing member of the Case Review Group to enhance the working relationship.

3.27. Learning and recommendations have been consolidated into action plans and are used to monitor progress. As part of the ongoing review, plans are in place to introduce a small working group to streamline and increase the effectiveness of the implementation of the action plans. This piece of work will in the spring of 2021.

3.28. Immediate learning is evidenced in Appendix C, it contains 2 examples:

- A 7-minute briefing for CLCH NHS Trust staff following RR10
- An all staff 'message of the week' for CNWL NHS Trust following RR8

3.29. The following section itemises the good practice and significant local learning identified from the Rapid Reviews conducted during the period under consideration.

Learning and recommendations identified from Brent Rapid Reviews

Incident triggering Rapid Review		Significant Good Practice identified	Significant Local learning identified	National learning identified
RR1	Unexpected death of an 11-month-old child in dirty and unhealthy home conditions.	• Joint home visits between the Metropolitan Police and Paediatrician for Child Death • Effective evidence gathering by police photographers • The Child Death Rapid Response process worked well with good interagency cooperation. • The Metropolitan Police senior investigating officer who has since left Brent is continuing to supervise this case pending a verdict on cause of death from the Coroner.	• Where social care professionals working within the MASH revise a decision about the outcome of a case which effects subsequent actions by partners this decision should be conveyed to all partners as soon as practicable. • The Local Authority to consider giving all MASH practitioners restricted access to Brent's Social Care case management system (MOSAIC) subject to current rules regarding data access. • The Local Authority and Police give consideration about ensuring that all unexpected deaths are discussed at daily Integrated Risk Management meetings.	This case did not identify any national learning points.
RR2	Death of a teenager with chronic life-limiting health problems in another country.	• No specific points of good practice were identified during this Rapid Review.	• The exploration and identification of themes for learning in this death would be led by the Child Death Review process.	This case did not identify any national learning points.

Learning and recommendations identified from Brent Rapid Reviews

Incident triggering Rapid Review		Significant Good Practice identified	Significant Local learning identified	National learning identified
RR3	A pregnant teenager concealing the birth of her baby and subsequently disposing of the foetus.	• There was strong evidence of professional curiosity from both health practitioners and the Metropolitan Police MASH in identifying concerns with the teenager's attitude towards her pregnancy, her concealed birth and subsequent admission of the disposal of the foetus. • Metropolitan Police officers explored every opportunity (including trained dogs and specialist forensic experts) to try and find the remains of the child.	• Agencies to record full names of professionals when sharing and receiving information and referrals. • As a result of identified gaps in internal information sharing within one local health services provider, a Serious Incident (SI) investigation was carried out. The findings and actions identified have been shared with the Case Review Group. • The GP to follow up as they would do a 6 weeks post birth physical examination and offer the support options available to the teenager in relation to her health and wellbeing.	This case did not identify any national learning points.
RR4	Gang-related murder of a teenage boy.	It was agreed this case met the criteria to conduct a Serious Case Review (under the previous LSCB arrangements) Awaiting publication of Child K Serious Case Review		
RR5	5-year-old child with serious injuries consistent with severe sexual & physical abuse	• There was excellent working together, communication and information sharing from Brent CYP and the Metropolitan Police with other relevant agencies. • Brent's response to the incident was considered exemplary in supporting the child following the trauma • The school has been kept informed and involved throughout by the Local Authority and the Metropolitan Police, support has been provided to the school by the other Local Authority's schools liaison team.	• Where possible, professionals should seek to clarify the structure and relationships within a family and ensure that records for both adults and children in the family are grouped together accordingly. • All agencies where appropriate should review their arrangements set out to assess the suitability of volunteers working within a service where known family members are also clients receiving these services to ensure full impartiality and maintain clear boundaries within these roles. • Initial strategy discussions should also include relevant health professionals when deciding to conduct s.47 investigation	The CSPR Panel to challenge the Crown Prosecution Service to consider their threshold for decision-making in such cases when they are seeking statements from vulnerable and traumatised children and also consider the limitations placed upon the police when required to release suspects under investigation in charging decisions.

Learning and recommendations identified from Brent Rapid Reviews

Incident triggering Rapid Review		Significant Good Practice identified	Significant Local learning identified	National learning identified
RR6	A teenager displaying mental health concerns and potential ASD sustained injuries in a possible suicide attempt.	• All professionals demonstrated their awareness of their safeguarding responsibilities and the majority of incidents referred to Brent Family Front Door as soon as was practicable. • It is encouraging to see evidence of so many agencies embedding safeguarding procedures in their operational practices. • The London Ambulance Service immediately put in place a mechanism to ensure safeguarding referrals are made at the time of the incident, where appropriate.	• As a result of this incident one local health services provider carried out a Serious Incident (SI) investigation and another carried out an internal management review. The findings and actions identified were shared with the Case Review Group. • Whilst there is strong evidence that the young person's wishes and feelings were documented, there is little evidence of what consideration was given to balancing these wishes against presenting information. Where appropriate, agencies should consider resolution mechanisms based around the needs of the child.	The Rapid Review heard that it is common practice nationally to offer children over 16-years old the choice to be treated in adult hospital wards. As the approach and responses are radically different between paediatric and adult wards, this case raises concerns about some of the complexities of transition from childhood to adulthood.
RR7	13-year-old child with mental health concerns attempted suicide.	• There is evidence of strong partnership working, effective communication and information sharing between multiple agencies • There is evidence that the child's wishes and feelings were heard and appropriately responded to across the partnership. • There was evidence that the partnership considered and documented the cultural needs and sensitivities of this family.	• Where agencies experience difficulties in the use of interpreters both face to face or virtually, they should consider a more flexible approach to accessing multiple approved interpreter services to enable alternative arrangements when a commissioned provider has limited availability. • Where families have a range of support needs (e.g., other children with SEN) agencies should consider what additional support can be offered (e.g., respite) to enable parents to focus on the management of a child's mental health crisis. • Agencies should ensure that as much historical/background information as possible is obtained from asylum seeking families when they access services.	This case highlighted some significant points of good practice in addressing the known national issue of a shortage of Tier 4 CAMHS provision. The Rapid Review agreed that this service should be brought to the attention of the CSPR Panel to share as an example of good practice nationally.

Learning and recommendations identified from Brent Rapid Reviews

Incident triggering Rapid Review		Significant Good Practice identified	Significant Local learning identified	National learning identified
RR8	7-year-old child victim with life changing injuries of a domestic related stabbing	• There is evidence of strong partnership working, effective communication and timely information sharing between the Local Authority, the Metropolitan Police and health service providers multiple agencies both before and after the incident • There is clear evidence that professionals are aware of their responsibilities in responding to domestic abuse incidents and are aware of MARAC procedures and referral criteria. It was encouraging to note that professionals do not appear to be delaying any interventions by waiting for a MARAC meeting to take place.	• When recording information about 'significant' males in the household/family composition, professionals must record this information clearly and precisely and where possible link family members together on systems. • There appears to be an assumption that when perpetrators of domestic abuse leave the family home, the associated risks have also been removed and the situation becomes safe for the child. Staff should be reminded to consider the risks the perpetrator still poses to the child/ren even though they have left the family home. • This case highlights the need for professionals to adopt a 'Think Family' approach and there are some crossovers with adult support services.	The CSPR Panel are asked to remind court officials of their safeguarding responsibilities in relation to private court proceedings where information is disclosed that may indicate safeguarding risks to the child/ren.
RR9	2-year-old child with possible life changing injuries from being the victim of a gang related shooting	• Two London Hospital Trusts involved demonstrated good practice following the incident by ensuring the hospitals remained a safe place, consistently communicating with the family and other agencies involve and offering trauma support for the siblings who witnessed the incident. • The local authority demonstrated good practice by liaising closely and sharing information with other boroughs to enable safety planning for the child, their siblings	• Police and Local Authority to consider including a pathway to routinely share gang information/ intelligence with health colleagues in the recently updated Integrated Risk Management (IRM) arrangements and provide assurance to the safeguarding partnership that the current IRM arrangements are fit for purpose and work effectively. • Police and Local Authority to remind their staff that appropriate health colleagues should be included in strategy discussions. • Where there are children living in other boroughs who are linked to known/suspected gang members, Brent CYP should consider including other boroughs in strategy meetings to avoid duplication and enable information exchange channels so that all children are safeguarded.	The CSPR Panel should recommend it is best practice that all health service providers have policies regarding non-attendance at routine child health appointments and monitor child health appointment attendance as a safeguarding key performance indicator data.

Learning and recommendations identified from Brent Rapid Reviews

Incident triggering Rapid Review		Significant Good Practice identified	Significant Local learning identified	National learning identified
RR10	Murder of a 5-month-old baby.	• The GP ensured the baby received immunisations despite restrictions imposed by the Pandemic • The midwifery staff identified mother as 'High Risk' and implemented the appropriate guidelines • The local authority liaison with the Metropolitan Police to provide support and alternative accommodation for other displaced occupants of the property where the murder took place. • The Metropolitan Police offered families and direct witnesses victim support.	• The Rapid Review recognised that the majority of learning from this incident is for health service commissioners and providers. Therefore, the Rapid Review made recommendations to the Hospital Trust (midwifery services) and CLCH NHS Trust (health visiting service) to include a number of areas for consideration as part of their internal serious incident review processes. • Pending the conclusion of the internal reviews the health commissioners for Brent conducted a table top audit review workshops in October/November 2020. Results of this work will be communicated to the Case Review Group. • The CLCH review identified a number of areas for learning within their organisation and the following is applicable to partners: ○ Provision of appropriate interpreting services ○ Communication gaps between services (HV, GP, midwifery, social care) ○ Staff stress/anxiety levels due to Covid-19 and trauma from past violent incidents involving children.	A recommendation was made for the CSPR Panel to remind airlines to; • be more vigilant when allowing pregnant women to travel • ensure airline staff are aware of the need to query visibly pregnant passengers before they travel • consider how they support and share information regarding the travel arrangements for pregnant women known to be over 28 weeks gestation with relevant the authorities/agencies

Identifying good practice

3.30. The Rapid Reviews undertaken in Brent since April 2019 have identified a significant amount of good practice which demonstrates strong partnership working. This is evidenced by the following case study.

Good Practice Case Study – Child B

Brent Council notified the Child Safeguarding Practice Review Panel of a serious safeguarding incident involving Child B, a thirteen-year-old who attempted suicide whilst under community mental health care during the COVID-19 Pandemic.

During the Rapid Review discussions, a significant number of good practice points were identified:

- Safeguarding concerns were identified and shared appropriately by health organisations in-line with policies and procedures.
- All professionals built good connections with the family and developed strong family engagement
- Evidence of strong partnership working, effective communication and information sharing between multiple agencies, notably mental health services, Brent CYP and School worked together to assess risks, co-ordinate the Child In Need Plan and manage integration back into education after a previous mental health crisis through thoughtful practices aimed to make transition successful.
- The child's wishes and feelings were heard and appropriately responded to across the partnership, for example the mental health crisis team worked with the child and family to enable their wishes that the child receive care in the community, rather than in hospital when it was felt safe to do so.
- There was evidence that the partnership considered and documented the cultural needs and sensitivities of this family.
- The multi-agency interventions were appropriate especially considering the additional Covid-19 restrictions in place.
- Agencies appropriately considered and responded to the impacts of the child's mental health breakdown on her family through culturally sensitive interventions.
- Despite the restrictions imposed by the Covid-19 Pandemic, the multi-agency response to the serious incident that triggered the Rapid Review was sensitive and thorough.
- All assessments undertaken by agencies in this case were detailed, informed objective.

The Rapid Review also identified areas that were felt to be outstanding practice:

- A significant amount of partnership planning, preparation and support took place prior to the child's discharge from hospital to home.
- There was regular and responsive care and support delivered safely in the home by both Brent CYP services and mental health services during the Covid-19 lockdown period.
- Agencies identified the need for more assertive outreach support as a result of both language, cultural and engagement difficulties with the family.
- This case highlighted some significant points of good practice in addressing the known national issue of a shortage of Tier 4 CAMHS provision and the Rapid Review agreed that this service should be brought to the attention of the CSPR Panel to share as an example of good practice nationally.

4. Other activities

Transitional Safeguarding

4.1. In May 2019, Brent Children's Trust led a discussion on transitions between services for children and young people and services for adults. This discussion highlighted that in many cases, support for young people could change drastically, be delayed or cease altogether when they reach their 18th birthday.

4.2. The Chairs of the former Brent LSCB and the Safeguarding Adults Board expressed their support to explore this important subject in Brent and agreed that it would be a positive step to jointly co-ordinate a workshop around Transitional Safeguarding.

4.3. The workshop took place on 7 November 2019 and Dez Holmes, Director of Research in Practice and Research in Practice for Adults facilitated the event.

4.4. The workshop was attended by a number of senior officers and strategic lead representatives from a wide range of partner organisations in Brent including:

Safeguarding Partners	
Brent CCG	Assistant Director Brent CCG Clinical Director Brent CCG
Brent Council	Brent Council Chief Executive Strategic Director Children and Young People Strategic Director Community Wellbeing Learning Disabilities Manager Head of Adult Social Care Transformation Head of Localities Service Operations Manager Early Help Head of Inclusion 0-25 Integrated Children with Disabilities Service Manager Youth Offending Service Manager Service Manager, Quality Assurance and Localities Troubled Families Co-ordinator Service Manager Brent Family Front Door Director of Public Health Public Health Consultant Change Manager Strategic Partnerships Team Head of Housing Needs Community Safety Manager
Metropolitan Police	North West Borough Command Unit (BCU) Safeguarding
Agency/Organisation/Individual	
Central North West London Mental Health Foundation Trust	
College of North West London	
London Probation	
Mike Howard Michael Preston-Shoot	Independent Convener Brent Safeguarding Forum Independent Chair Brent Safeguarding Adults Board

4.5. Senior colleagues from Westminster and Hammersmith also attended as they had also expressed an interest in exploring this issue.

4.6. Dez Holmes delivered an engaging presentation designed to challenge current practice and enable critical thinking and discussion about transitions in the widest sense.

4.7. Colleagues were encouraged to reflect on current practice and consider learning from parts of the wider system where transitional approaches are more embedded including:

- How contextual safeguarding and other innovations in children's safeguarding could inform safeguarding of young adults.
- Best practice from safeguarding adults could inform safeguarding adolescents (rights-based approaches, Making Safeguarding Personal and wellbeing focus).

4.8. Leaders were encouraged to consider the benefits of building capacity through local system redesign, in turn, investing in preventative and recovery-oriented work with the intention of avoiding the costs of later intervention (Invest to Save concept).

4.9. Colleagues from Havering attended to share their experiences of developing a more transitional system approach.

4.10. Brent has already begun to take positive steps in developing a transitional system approach and colleagues from the newly established Brent Children with Disabilities 0-25 Service shared their experiences.

4.11. Other positive foundations that Brent have put in place include:

- The strengthening of Brent Parent Carer Forum (BPCF)
- Offering opportunities for Directors and senior managers to meet with young people.
- Developing a dedicated support hub for children and young people living in care or leaving care.
- Inviting Care Leavers to attend and advise the Brent Corporate Parenting Committee.
- Preparing transitional packages of support for children at an earlier stage (e.g., Primary School age) to enable more seamless transitions.
- Arranging an annual care leaver's celebration event.
- CAMHS service planning to extend to 25 years old.
- Introduction of the Brent Community Safety Violence and Vulnerability programme to broaden out the Integrated Offender Management

4.12. The Safeguarding Partnership plans to review progress in 2021 together with the Brent Children's Trust and Brent Safeguarding Adults Board.

Multi-agency learning and development

4.13. The Safeguarding Partners continue to offer a multi-agency learning and development programme built upon the previous LSCB programme.

4.14. The programme is coordinated by the part-time Strategic Partnership Learning and Development Coordinator and the multi-agency Learning and Development Advisory Group, which reports into the Safeguarding Forum.

4.15. The programme is aimed to comprise of a range of different learning opportunities including;

- e-learning modules
- themed briefings
- awareness raising events
- joint learning events/sessions with other strategic partnerships including Brent Safeguarding Adults Board

4.16. The Learning and Development Advisory Group utilised the findings of the Section 11 audit conducted in May 2019 to shape the 2019/2020 multi-agency learning and development programme.

4.17. The Safeguarding Children Forum is kept regularly updated of the multi-agency learning programme through a standing item at each meeting.

4.18. In October 2019, the new joint multi-agency children and adults safeguarding partnerships learning management system (LMS) was successfully launched. The Brent safeguarding partnership learning site now offers professionals and volunteers who work / live in Brent full access to the multi-agency learning events and sessions from both the children's and adult's learning agenda.

4.19. A benefit of this new partnerships learning site is that delegates are able to register and book onto all sessions offered (safeguarding children and/or adult focussed topics). This allows for an increased multi-agency audience at sessions.

4.20. The new learning management system is also able to generate detailed reports on individual organisation attendance, non-attendance and cancellations. It also offers a comprehensive evaluation framework to monitor knowledge transfer and improved outcomes of the learning.

4.21. In early 2020, the Learning and Development Advisory Group agreed to fully integrate the learning from local and national case reviews into the training offer, this would include quarterly face-to-face sessions as well as monthly briefings.

4.22. The majority of sessions offered were classroom-based training. During 2019/2020, the Covid-19 pandemic impacted on the delivery of the multi-agency learning and development offer in a number of ways:

- All classroom-based sessions were cancelled during the first UK lockdown which began in March 2020.
- Members of the Strategic Partnerships Team who coordinate the partnership work were redeployed for a period of time to support the Council's Covid-19 response.
- The full multi-agency learning and development programme was put on hold until September 2020.
- The sensitive nature of some topics (such as FGM) means that they are not suitable to move to a full virtual offer.

4.23. From September 2020, work resumed on a new virtual multi-agency schedule including planning for the programme to focus on learning from local reviews.

4.24. A time limited working group was set up to look at the themes from the 10 local rapid reviews and one key theme identified is domestic abuse:

- The findings from one rapid review have led to the re-development of the multi-agency domestic abuse virtual sessions is planned to be rolled out from early 2021 as well as additional learning briefings.

4.25. Following the Transitional Safeguarding event which took place in November 2019, joint sessions are being developed to raise awareness of this topic across the safeguarding workforce in Brent from the spring of 2021.

4.26. Following the Transitional Safeguarding event which took place in November 2019, joint sessions are being developed to raise awareness of this topic across the safeguarding workforce in Brent from the spring of 2021.

Multiagency learning and development programme summary 2019/20

Event	Sessions	Offered Places	Bookings	Cancellations	Attended	No shows
Advance Charity Domestic Abuse Awareness	4	85	52	6	46	6
Advance Charity Domestic Abuse MARAC Training	1	25	19	1	13	6
Advance Charity Domestic Abuse Risk Assessment and Safety Planning	1	25	16	0	14	2
Honour Based Violence and Forced Marriages	1	0	11	1	11	0
FGM - Female Genital Mutilation	1	20	9	6	8	1
Prevent and Radicalisation	2	45	26	6	22	4
Reducing Parental Conflict: Module 1	1	20	0	0	0	0
Safeguarding Young Carer Training	1	14	14	1	14	0
TOTAL	**12**	**234**	**147**	**21**	**128**	**19**

4.27. As a result of the global pandemic there has been a reduction in training courses offered in 2019/20 (12 courses and 1 joint learning event compared to 47 courses in 2018/19). This has meant the overall number of recorded places taken up has decreased from 433 people in 2018/19 to 234.

4.28. Despite fewer sessions offered this year, it is clear to note that no shows and cancellations have reduced, this could be credited to the ease of accessing virtual sessions.

4.29. Staff and volunteers from education settings and Brent CYP continue to be the highest proportion of attendees, as well voluntary service that includes faith settings and community organisations. There continues to be low attendance from probation services and the Metropolitan Police, although there has been a slight increase from the previous year.

4.30. Review of learning and development offer:

- Using the results of the Safeguarding Survey to inform the learning programme.
- The learning and development advisory group remains confident that the multi-agency training offered continues to be relevant and of good quality.
- Feedback from evaluation forms would suggest the session are successfully being valued by delegates and is helping to contribute towards positive outcomes for children and young people.

Plan for 2020/2021

4.31. The Brent SCF learning plan for 2020/21 is to continue to offer effective sessions that promote improved outcomes of care for children and young people.

4.32. We plan to improve practices by enhancing communication with partnerships that offer single agency sessions as well as ways to support them in including follow up from training sessions

4.33. The following topics are planned sessions that will be run once every quarter:

Lessons learnt from local safeguarding cases	Transition planning
Brent specific Domestic abuse sessions	Think family
County Lines and Cuckooing/Home Takeovers	Adolescent mental health
Identifying and responding to modern slavery	Forced marriage
Working with families who are hard to engage	

4.34. We were due to initiate the new cancellation fee for ‘no shows’. However due to the pandemic this has been put on hold and is planned to be introduced in 2021.

4.35. As a result of the transition of learning to virtual sessions, it is anticipated that the part time learning and development coordinator will need to spend more time supporting these sessions.

4.36. Research in Practice have been commissioned to deliver 4 sessions focussing on transitional safeguarding. These sessions have been developed in partnership with the adults safeguarding board and are open to delegates working across safeguarding children and adult services.

APPENDIX A

Brent Serious Safeguarding Incident/ Rapid Review
Fact Finding and Decision Making Proforma

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.**

The local authority must notify any event that meets the following criteria to the National Panel *(within 5 working days);*

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.**

Chapter 4 Working Together 2018

Name/s of Child:	
Address	
NHS Number	
Date of Birth	
Date of Death (if applicable)	

Date of Incident	

Summary of incident	

Details of known Family Members and Significant Others

Name	Relationship to child	Date of Birth (age)

Is there any information available that evidences abuse/neglect in this case at this time?	**Yes ☐ No ☐** **Comment:**
Is there evidence that leads you to suspect abuse/neglect in this case at this time?	**Yes ☐ No ☐** **Comment:**
Has this event been discussed with the Brent Safeguarding Forum Convener?	**Yes ☐ No ☐** **Comment:**
Has this event been discussed with the Brent CCG Designated Professionals and the Met Police Safeguarding Lead?	**Yes ☐ No ☐** **Comment:**
Preliminary fact-finding information sought (CCG to include any information from health provider known to be involved)	

Decision made	**Make notification to national panel ☐** **Do not make notification to national panel ☐**

Rationale for decision following criteria	

Approved By	

APPENDIX B

Brent Rapid Review Initial Scoping and Information Sharing

Working Together 2018 introduces a requirement to undertake a multi-agency 'Rapid Review' whenever a notification of a serious incident has been received. The 'Rapid Review' is intended to inform the decision-making around whether to undertake a child safeguarding practice review. A notification of a serious incident has been made and therefore, we will be holding a Rapid Review to consider the case.

Purpose of the Rapid Review

In line with *Working Together 2018*, the aim of this Rapid Review is 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 Local Child Safeguarding Practice Review (LCSPR).**
- **decide whether the LCSPR criteria have been met, the reasons for the decision, and whether the case may raise issues, which are complex or of national importance such that a national review may be appropriate.**

To inform the Rapid Review meeting, we need to gather the basic facts about the case and determine the extent of agency involvement with the child and family.

We are required to hold the Rapid Review meeting and agree the way forward within timescales outlined in national guidance (currently within 15 working days). This initial scoping and information sharing form should therefore, be returned to us **by XX/XX/XXXX**.

Contact details of individual / agency completing this form

Name	AGENCY & DESIGNATION/TITLE	CONTACT DETAILS – Address, telephone number and e-mail address

Date completed:

Background Information

Summary of Case:

Time period:

Composition of the Child's Family

All agencies are asked to check whether the details below match information held on their systems. Please notify us of any anomalies.

SUBJECT CHILD:	
NHS number:	
D.O.B:	
Ethnic Origin	
Current home address:	
Known previous addresses:	
Date of serious incident	

Known significant others

Name	Relationship to Child	Date of Birth

1.	**Please include here relevant information about any additional family members / significant others who are not listed above**

2.	**Brief summary of your agency's involvement with the subject child AND the individuals listed in the family composition.** *(Please focus on the **key significant events** in chronological order and, where appropriate, include the date of commencement and completion of service.)*
Date DD/MM/YYYY	**Summary of Involvement**
Additional information (optional)	

3.	**Brief analysis of individual/agency practice.** *(Please identify any outstanding practice or potential learning).*

4.	**Please identify any areas for concern as to the way in which partners have worked together to safeguard the subject child.**

5.	**Please include any further relevant information that you wish to bring to the attention of the Rapid Review meeting, including highlighting good practice.**

6.	**Based on the information you are currently aware of; please indicate your recommendations for the Rapid Review to consider as next steps** (*e.g., Local Safeguarding Practice Review, consideration of Domestic Homicide Review and/or Safeguarding Adult Review)*

NHS
Central London Community Healthcare
NHS Trust

1 Incident, context and outcome

London Ambulance Service were called to the family home.

A 5-month old child was found to be deceased with fatal knife wounds.

His mother was arrested in connection with his death.

The mother had been on the Health Visiting team caseload.

2 Care and/or service delivery problems include:

- Need for interpreter not identified prior to NBV therefore NBV was not completed fully.
- Postnatal discharge summary was saved only to baby's record (not mother's)
- Mother's history of post-natal depression not known prior to NBV therefore family were incorrectly allocated to 1a level on LCON
- Repeat/follow-up NBV with interpreter was not completed.
- Failure to Attend policy and processes were not followed regarding offer of 2nd appointment for the 6-8 week contact

3 Contributory Factors include:

- Language and cultural barriers
- Incomplete maternal history impacted on identification of vulnerability
- Gap in process for managing DNAs
- Workload/capacity of staff – large caseload/number of tasks
- No system in place to identify incomplete contacts
- Lack of professional curiosity
- Communication gaps between services (HV, GP, midwifery, social care)
- Excessive focus on KPIs
- Health Visiting caseload SOP launched in December 2019 - not embedded in practice or widely known about in the borough
- High levels of vulnerability in the population/caseload - impact on thresholds regarding risk and vulnerability.
- Staff stress/anxiety levels due to Covid and past violent incidents

4 Root causes

No root cause identified for death of baby – police and GP information suggests mother and baby were interacting well shortly before baby's death.

5 Recommendations include:

- Clients should be asked which language is spoken at home when booking NBV and interpreter booked if necessary
- HVs should be advised to review discharge summary prior to all NBVs
- Review of HV/GP and HV/midwifery liaison processes
- Review of process for how to manage an incomplete contact and booking a follow-up visit
- Consider how professional curiosity can be developed in the HV workforce
- HV Caseload SOP should be reviewed updated and recommunicated to all HVs across the division
- Caseload sizes within the borough should be reviewed

6 Learning:

- Use of interpreter at NBV would have allowed completion of NBV and possible identification of vulnerability
- Importance of liaison with other services/agencies
- Importance of professional curiosity regarding unusual circumstances e.g. enhanced maternity care
- Smaller caseload sizes could support more timely follow-up visits

7 Discussion points

Could this type of incident happen in your team?

What can you do to foster professional curiosity in your team?

Central and North West London NHS
NHS Foundation Trust

Clinical Message of the Week –2020

Separation is a time of increased risk for victims of Domestic Abuse

Evidence: Victims are most at risk of escalating *abuse after* leaving a controlling partner. 74% of Domestic Homicides are at separation or after. All family members, including children, are at increased risk during this time. The risks continue and are heightened for the family where the alleged perpetrator has ongoing contact with the children (SAFELIVES, 2018).

- It is still commonly assumed that simply leaving the family home or separating from an abusive partner will reduce the risks for victims of Domestic Abuse.
- Clinicians should recognise that separation can be a long, gradual process involving a number of incremental steps.
- These steps might include making the disclosure, talking to an Independent Domestic Violence Advocate and involving the police. A victim can be at increased risk of harm at any stage of this process – and afterwards.
- What can you do? **Never simply tell someone that they need to leave a relationship**. Talk to the victim about the increased risks associated with separation and work with them (and family- where safe and appropriate) to plan the **safest way of separating. This will often involve the support of specialist organisations.**
- **Stay in touch with the victim and be persistent in attempting to re-engage if they start to move away from the support offered.**

Always consult your local Safeguarding Leads/Named Professionals for advice when needed- contact details on Trustnet
Link to Domestic Abuse policy

If you are interested in becoming a Domestic Abuse Ambassador – please email Susan Bray (Named Professional for Safeguarding Children /Domestic Abuse Lead) susanbray1@nhs.net

Guidelines for clinical message of the week

- **Spend no more than 2- 3 mins on the given message highlighting why it is so important**
- **Do this at every handover, night and day shifts for 1 week and staff briefings**
- **Aim is to capture as many staff as possible and share learning**