MK TOGETHER
Safeguarding Partnership

MK Together Partnership Collaborative Learning Threshold and Process Document

Foreword

The MK Together Partnership, incorporating Safeguarding Children and Adults, and Community Safety, is committed to continuous improvement through learning together. This document sets out the commitment and expectation for collaborative partnership learning via statutory, non-statutory and single agency reviews, the methods by which reviews are considered and escalated for disagreement.

This document will be reviewed on an annual basis in line with Working Together to Safeguard Children 2023, The Care Act 2014, and Home Office Domestic Homicide Review guidance currently under review.

Purpose of a Statutory Review

Legislation places duties on Local Safeguarding Children Partnerships (LSCPs), Safeguarding Adult Boards (SABs) and Community Safety Partnerships (CSPs) to derive learning from incidents that occur within the partnership area. The purpose of a statutory review is to identify areas for systemic and operational improvement to safeguard vulnerable children and adults and to identify and share areas of good practice in order to prevent similar incidents occurring in the future.

Statutory reviews are carried out by a suitably experienced and qualified person who is independent of the partnership.

Statutory reviews do not replace or supersede criminal, coronial, or HR investigations and do not seek to blame individuals.

Purpose of a Collaborative Learning Exercise

The purpose of a Collaborative Learning Exercise is to review near misses and incidents where it is agreed partners could have worked better together, with the aim of improving practice.

Collaborative Learning Exercises will be carried out by the MKTSP Review Group.

Cases where there has been disagreement around meeting the threshold for a serious incident notification (SIN) or SAR must not be referred to Review Group unless under the direction of the DSPs, LSPs or CSP.

Threshold:

Local Child Safeguarding Practice Review (LCSPR)	Safeguarding Adult Review (SAR)	DHR/Domestic Abuse Related Fatality Review (DARFR)	Local Collaborative Learning Exercise
SI notification: Abuse or neglect of a child is known or suspected, and The child has died or been seriously harmed* in the local authority's area or While normally resident in the local authority area, the incident occurs outside of England Highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previous identified Highlights or may highlight recurrent themes in safeguarding and promotion of the welfare of children Highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children Is one the national panel has considered and has concluded a local review may be more appropriate.	A case involving an adult in a SAB area with needs for care and support and: There is reasonable cause for concern about how agencies have worked together to safeguard the adult, and: The adult has died and the SAB suspects or knows the death resulted from abuse or neglect, or: The adult is still alive, and the SAB knows or suspects the adult has experienced serious abuse or neglect	A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by: A person to whom they were related or with whom they were in an intimate personal relationship, or A member of the same household *(relationship status is regardless of gender or sexual orientation)*	A child or adult with care and support needs is involved in an incident or incidents that **could have** resulted in death or serious harm. An incident or situation with a group of children or adults with care and support needs have identified areas of development within the partnership, for example, high risk missing children, concerns around care homes. Partners agree that whilst it does not meet the threshold for a statutory review, there is an opportunity to learn from the incident/s.

*Serious Harm – serious and/or long-term impairment of a child's mental health or intellectual, emotional, social, or behavioural development.	A SAR must be carried out in any case where a person known to be rough sleeping in the SAB area has died (new duty on SABs).	Includes cases of: • Controlling and coercive behaviour • Honour Based Abuse and Female Genital Mutilation • A person known to have experienced domestic abuse dies by suicide	
Incident occurs in the local authority area. While normally resident in the local authority area, the incident occurs outside of England			
Death of a looked after child or care leaver up to the age of 24 requires a notification to The Secretary of State for Education and Ofsted.			

Where the local case review panel believes the rapid review has identified all the learning, the local Panel may agree not to progress with an LCSPR or SAR.

Local partners **commit** to reviewing any case against the above criteria in any multi-agency meeting or internal review as appropriate including:

- Strategy Meetings
- Adult Risk Management Meetings
- Gold/Silver Meetings
- Action After Learning Events
- IOPC investigations
- NHSE investigations
- Patient Safety Incident Investigations under PSI Review Framework (PSIIRF)
- Internal incident reviews

Process for referrals for each review can be found in the appendices.

Single Agency Learning

Where agencies are carrying out single agency learning as listed above, they must consider if a statutory or Collaborative Learning Exercise threshold is met. Where it is they must refer in the agreed way (see appendices). Chairs/reviewers of both reviews will collaborate to ensure there is minimal duplication and agree a lead Chair/reviewer to have contact with the family.

Where the threshold is not met the Chair/Reviewer for the single agency review must consider if any learnings are relevant for the partnership. This may occur when but not limited to:

- There is good practice that other agencies can consider within their own service delivery.
- There are recommendations that include joint working with partner agencies.
- The agency feels there would be a benefit to the partnership in sharing the learning.

Where a single agency report is considered of value to the Partnership, it will be presented at Assurance Group.

Governance

Local Safeguarding Partners and Community Safety Partners

LSPs have overall responsibility for ensuring local partnership arrangements are in place to deliver on the statutory responsibility to carry out LCSPRs, and that learning is embedded into practice. At place this is overseen by Delegated Safeguarding Partners (DSPs).

Safeguarding Adult Boards have overall responsibility for ensuring local partnership arrangements are in place to deliver on the statutory responsibility to carry out SARs and that learning is embedded into practice.

In Milton Keynes these functions are carried out by the MK Together Safeguarding Partnership.

CSPs have overall responsibility for ensuring the local partnership arrangements are in place to deliver on the statutory responsibility to carry out Domestic Homicide Reviews, and that learning is embedded into practice.

Local Case Review Panel

The Local Safeguarding Partners have delegated local decision-making responsibility for whether a case meets the threshold for a statutory review to the Local Case Review Panels (LCRP) for children, adults, and domestic homicide. The LCRP will consider all Rapid Reviews to:

- Identify any immediate learning that needs to be implemented.
- Identify any good practice that can be shared system wide.
- Agree whether or not to progress to a statutory review, a collaborative learning exercise, or the case requires no further action.

Review Group

Review Board has strategic oversight of all ongoing statutory reviews ensuring they are completed in an appropriate timeframe and to a high standard *(ToR in MKT Handbook).* Following completion of a review, Review Group will agree an action plan to ensure agreed recommendations are taken forward.

Delivery Group

Delivery Group is responsible for carrying out all multi-agency actions agreed on completion of a review. Delivery Group is also responsible for ensuring agencies complete single agency actions. Members will be held to account for completion of their actions. *(ToR in MKT Handbook).*

Assurance Group

Assurance Group will receive updates on completion of action plans and decide what and how to test that practice has improved as a result *(ToR in MKT Handbook).*

Domestic Abuse Strategic Partnership Board (DASP) reporting to the Health and Care Partnership

The Chair of the DASP and the Domestic Abuse Co-Ordinator will be panel members for each DHR. Where agreed, actions may sit within this structure, in particular where it requires strategic change and development. The DASP will report to Delivery Group on progress of these actions.

Escalation of Disagreement:

Whilst it is the responsibility of the local authority to submit Serious Incident Notifications for Children to Ofsted, any of the Safeguarding Partners or agencies carrying out safeguarding functions can refer a case for consideration to the DSPs or via a strategy meeting.

Any Safeguarding Partner or agencies who carry out safeguarding functions can refer a case for a SAR or Collaborative Learning Exercise.

Police must inform the CSP of a domestic abuse related fatality in writing in order to commence a review. Any Safeguarding Partner, or agency that carries out safeguarding functions, may refer a case that hasn't already been notified to the CSP if it is believed that there are important lessons to be learned for inter-agency working.

Where there is disagreement between partners as to whether a case meets the threshold for a statutory review or collaborative learning exercise this must first be escalated to the Local Case Review Panel (LCRP) via the MK Together Team. The LCRP will then discuss and make a decision as to whether or not a case meets one of the thresholds.

Where there is disagreement amongst the LCRP, this will be escalated to the LSPs/SAB/CSP Chair for decision.

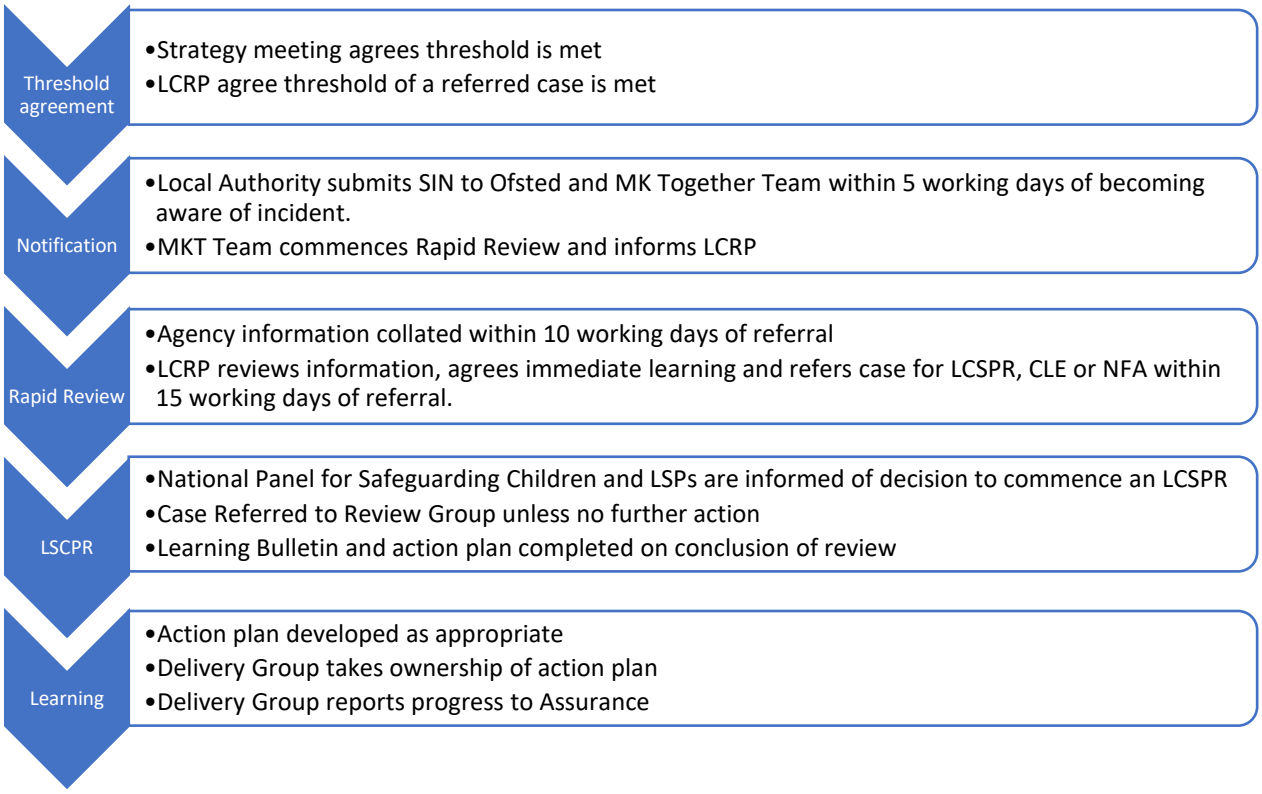
Role of the MK Together Team:

The MK Together team sits within the Partnerships and Resilience department in the local authority, however, they are an independent team employed to carry out the business of the MK Together Partnerships.

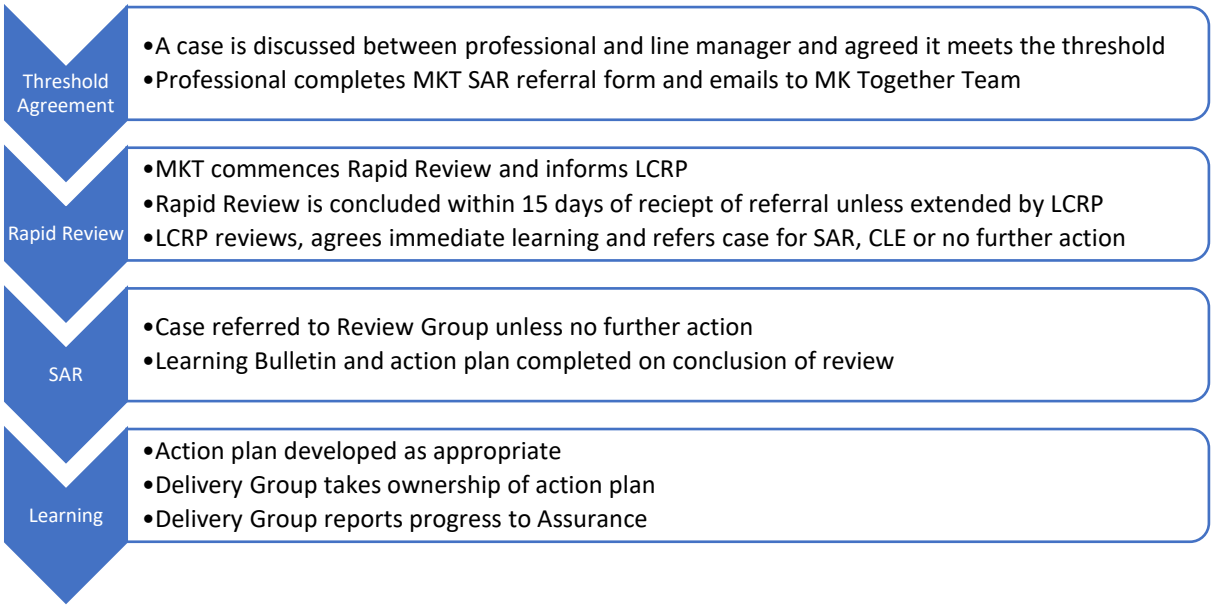
The MK Together team will support partners to make informed decisions and expedite the activity for reviews including:

- Collecting and collating information for all reviews
- Ensuring timely distribution of papers and draft documents
- Providing the administration for all group and panel meetings
- Running procurement for commissioning Independent Chairs and Reviewers

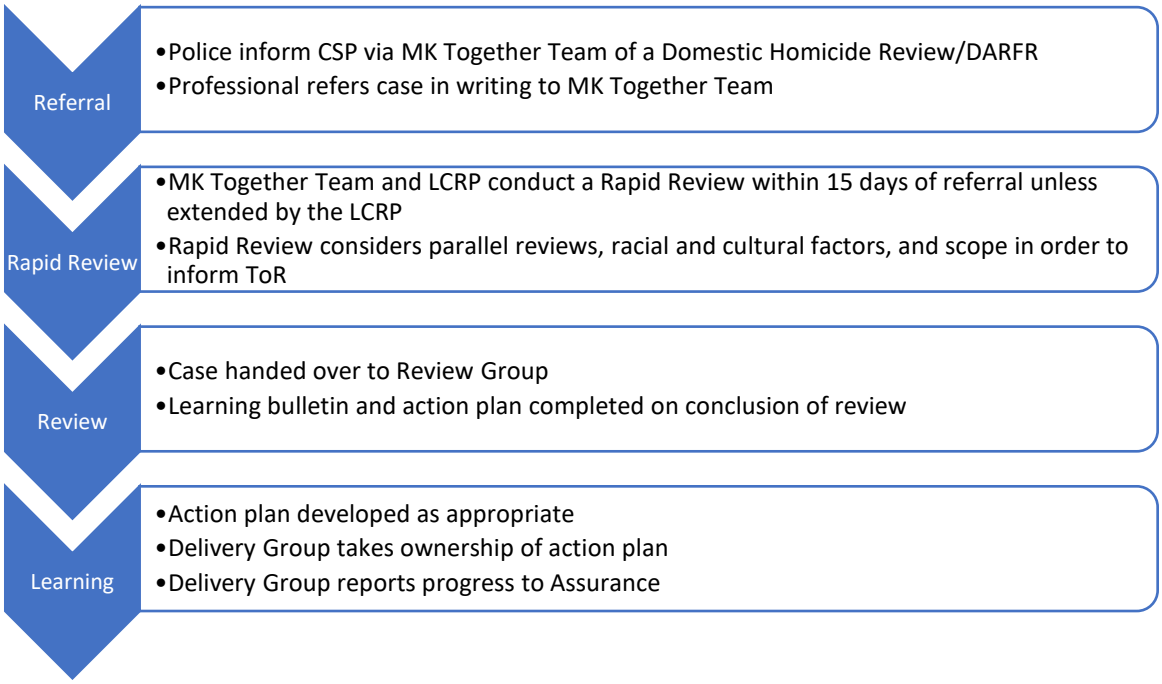
Appendix one: Referral for a Serious Incident Notification (SiN)/Local Child Safeguarding Practice Review (LCSPR)



Appendix two: Referral for Safeguarding Adult Review (SAR)



Appendix three: Referral for Domestic Homicide Review (DHR)/Domestic Abuse Related Fatality Review (DARFR)



Appendix four: Referral for Continuous Learning Exercise (CLE)