



# **Barking & Dagenham 'One Panel'**

# **Guidance, Terms of Reference (ToR), and Referral Form**

Version 1.5  
Published March 2024

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## 1. Purpose

The 'One Panel' is a multi-agency group which receives referrals on cases in Barking and Dagenham that may meet statutory review criteria, such as a Safeguarding Adults Review (SARs), Child Safeguarding Practice Reviews (CSPRs) or Domestic Homicide Reviews (DHRs).

The purpose of the Panel is to provide a multi-agency decision making forum for all referrals for statutory reviews against the relevant criteria and to make recommendations in respect of what type of review should be undertaken, if any. The focus of the panel is to identify opportunities for system-wide learning to improve practice. The Panel will also consider reviews published by other areas and national reviews to identify implications of local learnings lessons. The panel may also review learning from other non-statutory reviews for example, learning from drug related deaths, LeDeR, Fire Death Reviews etc., where system learning has been identified.

The Panel works within a 'Think Family' framework, so that when supporting any member of a family, the needs of the whole family are explored and considered, and all aspects of the safeguard system are addressed.

The Panel discusses the referrals and uses statutory criteria to make recommendations to the relevant board chair. The final decision is then made about what type of review will take place.

The Panel will also have oversight of any requests (through the activity tracker) for input or information by reviews led by other partnerships to ensure that learning is picked up and shared.

## 2. Chairing and Membership

Chairing on a 12 Month rotation, current Chair is the Barking and Dagenham Operational Director, Adults Care & Support

Membership will consist of senior officers from agencies members from the following agencies:

| Service/Organisation  | Role  | Delegated Rep                          |
|-----------------------|---|--|
| North East London ICB | AD Safeguarding Children                          |  |
|                       | AD Safeguarding Adults                            |  |
|                       | Designated Professional Safeguarding Children     |  |
|                       | Designated Professional Safeguarding Adults       |  |
| Met Police EA BCU     | Superintendent Public Protection                  |  |
|                       | Superintendent Safer Neighbourhood Team (DR)      |  |
|                       | Detective Chief Inspector (DCI) Partnerships Lead |  |
|                       | Integrated Care Director                          | Assistant Directors, Adults & Children |

|   |   |  |
|---|---|--|
| North East London Foundation Trust (NELFT)            | Named Professional Safeguarding Children              |  |
|   | Named Professional Safeguarding Adults                |  |
| Barking Havering & Redbridge University Trust (BHRUT) | Named Professional Safeguarding Children              |  |
|   | Named Professional Safeguarding Adults                |  |
| London Borough of Barking and Dagenham (LBBD)         | Operational Director, Childrens Care & Support        | Head of Family Support & Safeguarding Service      |
|   | Operational Director, Adults Care & Support           | Head of Service responsible for Adult Safeguarding |
|   | Principal Social Workers (Adults and Childrens)       |  |
|   | Head of Schools Performance and Partnership           | Head of Inclusion, Education                       |
|   | Operational Director, Community Safety Partnership    | Community Safety Manager                           |
|   | Head of Safeguarding and Quality Assurance (Children) |  |
|   | Head of Service, Housing/Homelessness                 |  |
|   | Head of Early Help                                    |  |
|   | Solicitor   |  |
|   | Public Health Lead                                    |  |
| Community and Voluntary Sector Lead Domestic Abuse    | Service Manager (Domestic Abuse) Refuge               |  |
| National Probation Service                            | Area Manager  |  |

### 3. Panel Meetings

The Panel will be scheduled to meet for 2hrs on the third Thursday of each month. A Panel meeting can be cancelled by the Chair if there are no new referrals and no requirement for critical decisions or significant updates in relation to ongoing cases. The Panel will not be considered quorate without representatives from the following agencies: health, children's social care, adults social care, community safety and the police.

On any occasion where additional meeting is required in between the monthly cycle, these will be arranged as One Panel Plus meetings by the Business Mangers for the strategic partnerships (who will also serve as the One Panel Business Unit)

Should a 'Rapid Review' be required (**see appendix a and b**) where a child has died or been seriously harmed AND abuse or neglect is known or suspected this can be carried out via the usual monthly One Panel meetings (if it's within the 15 day timescale set by the National Panel)

but it is likely that a dedicated 'Rapid Review' meeting would need to be arranged outside of the regular One Panel monthly meeting but this may also depend on what is on the forward plan or volume of new referrals. Professionals may be added to the Rapid Review/One Panel Plus and/or members removed as agreed by the Chair.

Initial Scoping/Information gathering should be supplied by the agencies referring into the One Panel on the One Panel Referral Forms (found at the bottom of this document).

If a Rapid Review is set up outside of the One Panel then Partnership Business Manager/One Panel Business Unit will send separate Rapid Review scoping templates to all the attendees.

## 4. Governance

The responsibility for screening referrals/cases has been delegated to the Panel by the Barking and Dagenham Safeguarding Adults Board (BD SAB), the Barking and Dagenham Safeguarding Children Partnership (BD SCP) and the Barking and Dagenham Community Safety Partnership.

The Panel discusses the referrals and uses statutory criteria to make recommendations to the relevant board or partnership for ratification. The final decision is then made about what type of review will take place.

The ongoing managements of any agreed reviews remains with the governance of the relevant board or partnership but an activity tracker will be shared with the named members of the group so the One Panel can assure itself of progress or be aware of any pertinent issues.

Should any members of the One Panel strongly disagree with the decision of the panel having discussed their concerns in the panel on threshold for statutory review, should in the first instance share their rational with their own agency leads especially if the individual review differs from the other agency members. The agency lead will then share the dissent with the Chair of the panel.

The chair will consider if the panel needs to reconvene to review the decision or raise with the Chairs of the BDSCP, BDSAB and CSP and the lead agencies for the final decision. Where agreement cannot be reached, the One Panel chair will have final say and should be supported by the Independent Chair and Independent Scrutineer.

## 5. Confidentiality

The contents of this meeting are strictly confidential.

This meeting will be recorded to ensure accuracy of minutes and/or analysis. All recordings will be deleted once the minutes are approved Information shared in this meeting is being provided on a strictly "NEED TO KNOW" basis and in accordance with multi-agency information sharing agreements. Participants will need to ensure the proper control and storage of information relating to this meeting and by agreeing to the confidentiality statement at the start of the meeting.

## 6. Roles and Responsibilities

The Panel Chair will:

- Be one of the statutory safeguarding partners, agreed by the joint BD SCP and BD SAB Executive.
- Rotate on a yearly basis.

- Report to the BDSCP, BDSAB and Barking and Dagenham Community Safety Partnership annually.
- Provide updates on individual case reviews as appropriate.
- Be supported by the BDSCP, BDSAB or CSP Business Manager
- Undertake an annual review of all cases referred to the panel. This will allow identification of any unconscious biases or themes in referrals that do not progress to reviews and identification of repetitive themes, for presentation at the boards and partnerships.
- Ensure business continuity of the process in unforeseen circumstances.

#### The Members will:

- Ensure they attend every panel or provide appropriate delegation.
- Will provide the panel with chronology of involvement by the agency for every case or indicate if not known to the service.
- Provide analysis of their service involvement understanding not only what happened but why.
- Be knowledgeable about potential indicators of abuse or neglect and domestic abuse.
- Actively contribute to discussion and decision making.
- Quality Assure any referrals made by their agency Panel Secretariat:
- Receive all referrals.
- Gather further information if required on the case.
- Support the Chair in development of the agendas and circulation of papers.
- Log all referrals including those that do not meet statutory thresholds and or do not progress to a review of any kind.
- Monitor the progress and status of any reviews.

#### Panel Administration:

- Receive all referrals.
- Gather further information if required on the case.
- Support the Chair in development of the agendas and circulation of papers.
- Log all referrals including those that do not meet statutory thresholds and or do not progress to a review of any kind.
- Monitor the progress and status of any reviews.
- A log of actions and key decisions only, will be made.

## 7. Process

When a professional believes that the criteria has been met on a case for DHR or SAR, the referral form is completed and submitted to the Panel [bdonepanel@lbbd.gov.uk](mailto:bdonepanel@lbbd.gov.uk)

In the case of children, the outcome of the Rapid Review (RR) is shared (or the original referral if it does not meet criteria for Rapid Review - **see Appendix a**). The referral should be made at the earliest opportunity following identification of a case. All referrals should be agreed and signed off by a Head of Service or equivalent. We would expect that that agency rep for One Panel would be briefed on their own agency referrals ahead of the meeting so that they are prepared for the discussion.

The Partnership Business Managers/One Panel Business Unit will review the referral and go back to the referrer if any further information is required. We ask that those making referrals to the One

Panel ensure that all available information is submitted otherwise this delays the process in getting the referral/case on to the agenda.

The Panel will consider the request at the next meeting. At the meeting, the Chair will remind Panel Members of the different criteria for each kind of statutory review (see **Appendix**). The Panel, via the Chair, will then make a recommendation to the statutory partners.

The Chair may decide that further information is required before the Panel can make a recommendation. In which case, the information will be sought by the Business team, circulated to Panel Members via e-mail and a decision made without a second meeting, unless this is required.

Each partner agency attending the Panel will have one vote, regardless of the number of individual representatives from the agency present. Where there are disagreements at the Panel regarding the most appropriate action in relation to a case, the Chair will escalate this to the statutory safeguarding partners for their final decision as per section 3.

## 8. One Panel Decision Making

The following section outlines the decision making and responsibilities of the One Panel. Although three separate areas are outlined, any case considered and reviewed by the One Panel will look at where a case may meet statutory requirements for all three types of review and agree that if they meet more than one which process may take the lead.

### Children

Initial Decision making is made outside of the One Panel via the Pre-SIN Discussion or SIN stage where there are strict timescales in place. If a SIN is made to the National Panel (more details in **Appendix A**) then a rapid review will be scheduled within 15 days of that SIN. The rapid review should include heads of service/non director level or seniority. If the decision is reached that the referral does not meet criteria for a rapid review, then the information is shared with the One Panel, to consider if there is any learning from the referral and how this may be undertaken. If the decision is made at the raid review that the threshold for a CSPR is not met, then this will also be shared with the One Panel to consider next steps for learning.

- Methodology options can be utilised to support suitable and proportionate learning (see **Appendix e**).
- The chosen form of review is undertaken and shared with the One Panel for discussion, scrutiny, and final comments.
- The Panel will agree how the learning will be shared and where responsibility for actions most appropriately sit.
- Any commissioned Child Safeguarding practice Reviews (CSPR) will be managed via the individual CSPR Panel formed to oversee the review.
- The final draft of the report will be shared with the one panel for discussion and agreement of actions in response to the findings.
- The CSPR final report will then go to BD SCP for final agreement and sign off and submission to the national CSPR Panel.
- Copies will also be sent to the Department for Education (DfE) and to Ofsted. The final report will be shared with the One Panel. Oversight for completion of actions sits with BD SCP.
-

## Adults

- The One Panel makes the decision to agree whether any referral meets the criteria for a Safeguarding Adult Review under the [Care Act 2014 S44](#) utilising **Appendix d** decision making tool
- If the decision is not to hold a statutory review the One Panel can consider if there is any learning from the referral and how this may be undertaken. **Appendix e** methodology options can be utilised to support suitable and proportionate learning.
- The outcome of the screening must be shared with the SAB. If a SAR is agreed this will be managed via the SAR Panel.
- The final draft of the report will be shared with the One Panel for discussion and agreement of actions in response to the findings. The SAR final report will then go to BD SAB for final agreement and sign off. The final report will also be shared with the One Panel. Oversight for completion of actions sits with the BD SAB.

## Domestic Homicide

- The One Panel makes the decision to agree whether any referral meets the criteria for a Domestic Homicide Review (DHR) utilising the domestic homicide decision support information at **Appendix c**.
- If the decision is not to hold a statutory review the One panel can consider if there is any learning from the referral and how this may be undertaken.
- **Appendix e** methodology options can be utilised to support suitable and proportionate learning.
- The outcome of the screening must be shared with the CSP who hold statutory responsibility for DHRs.
- If the threshold for DHR is met it will be commissioned and overseen by the CSP. The final draft of the report will be shared with the One Panel for discussion and agreement of actions in response to the findings.
- The DHR final report will then go to CSP for final agreement and sign off. Final report will be shared with the One Panel. Oversight for completion of actions sits with the CSP.

## 9. Commissioning Reviews

As well as making a recommendation to the statutory safeguarding partners on the type of review, the One Panel will also make recommendations in relation to the focus and methodology. The BD SAB, BD SCP and Barking and Dagenham Community Safety Partnership will be responsible for commissioning the review, including identification of independent reviewer.

## 10. Support for Staff

The One Panel recognises that whether referrals/reviews/serious incidents, have resulted in serious harm or death, this can be a very distressing time for practitioners. The Panel is committed to ensuring staff receive the support and guidance they need through all of the processes, statutory or otherwise.

Each agency will have its own policy and process on support for staff's wellbeing and we encourage managers to discuss this with their direct reports. Where support is needed for

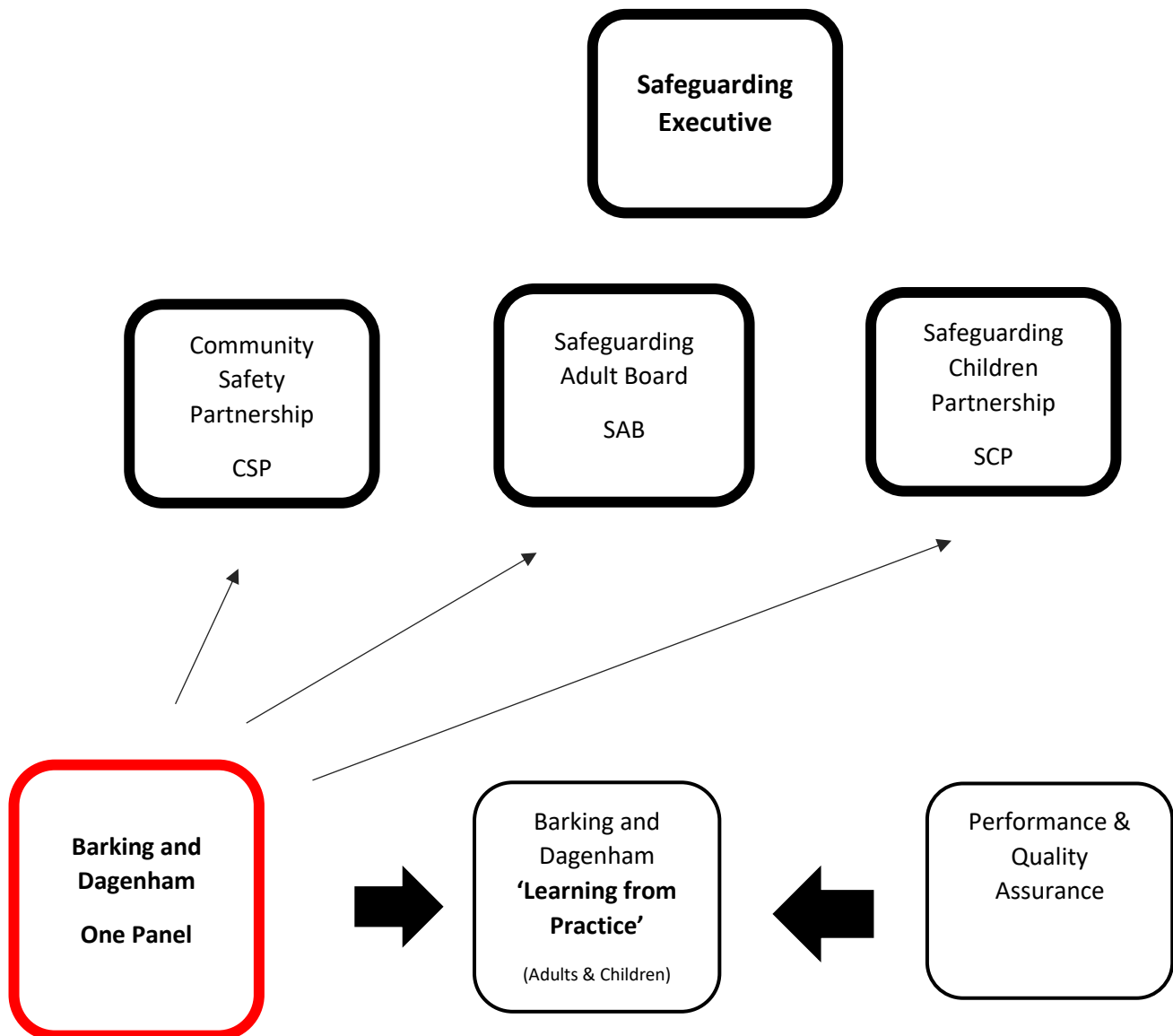


completion of documents or scoping templates then please contact the relevant partnership direct or the [bdonepanel@lbbd.gov.uk](mailto:bdonepanel@lbbd.gov.uk).

## 11. Review of the One Panel

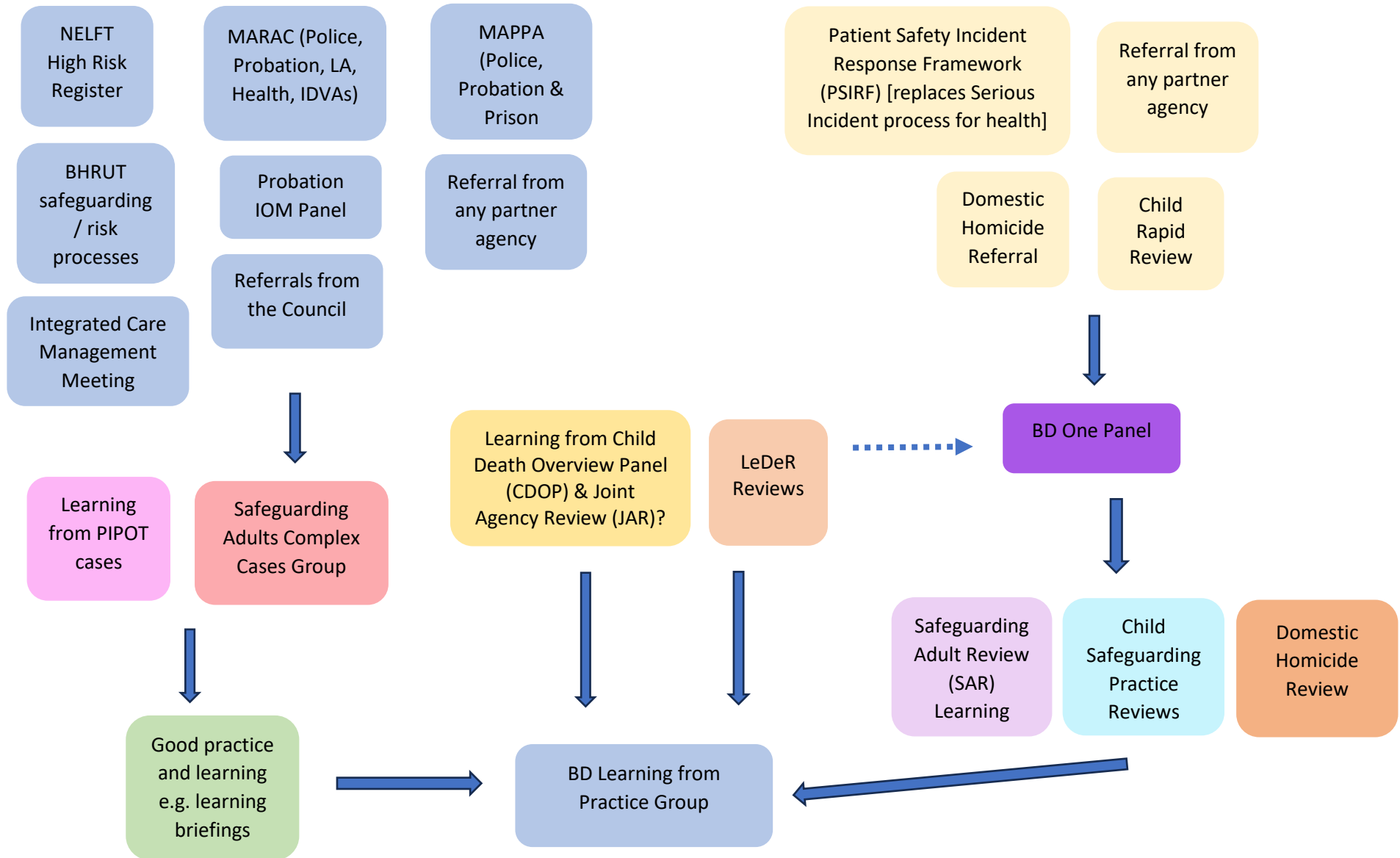
The One Panel and this guidance will be reviewed in full 12 months (Feb 2025) after the first panel takes place. Each quarter, an audit will take place to assess the quality of referrals and provide feedback and support where required.

## 12. Where does One Panel sit within the Partnership? Level 1





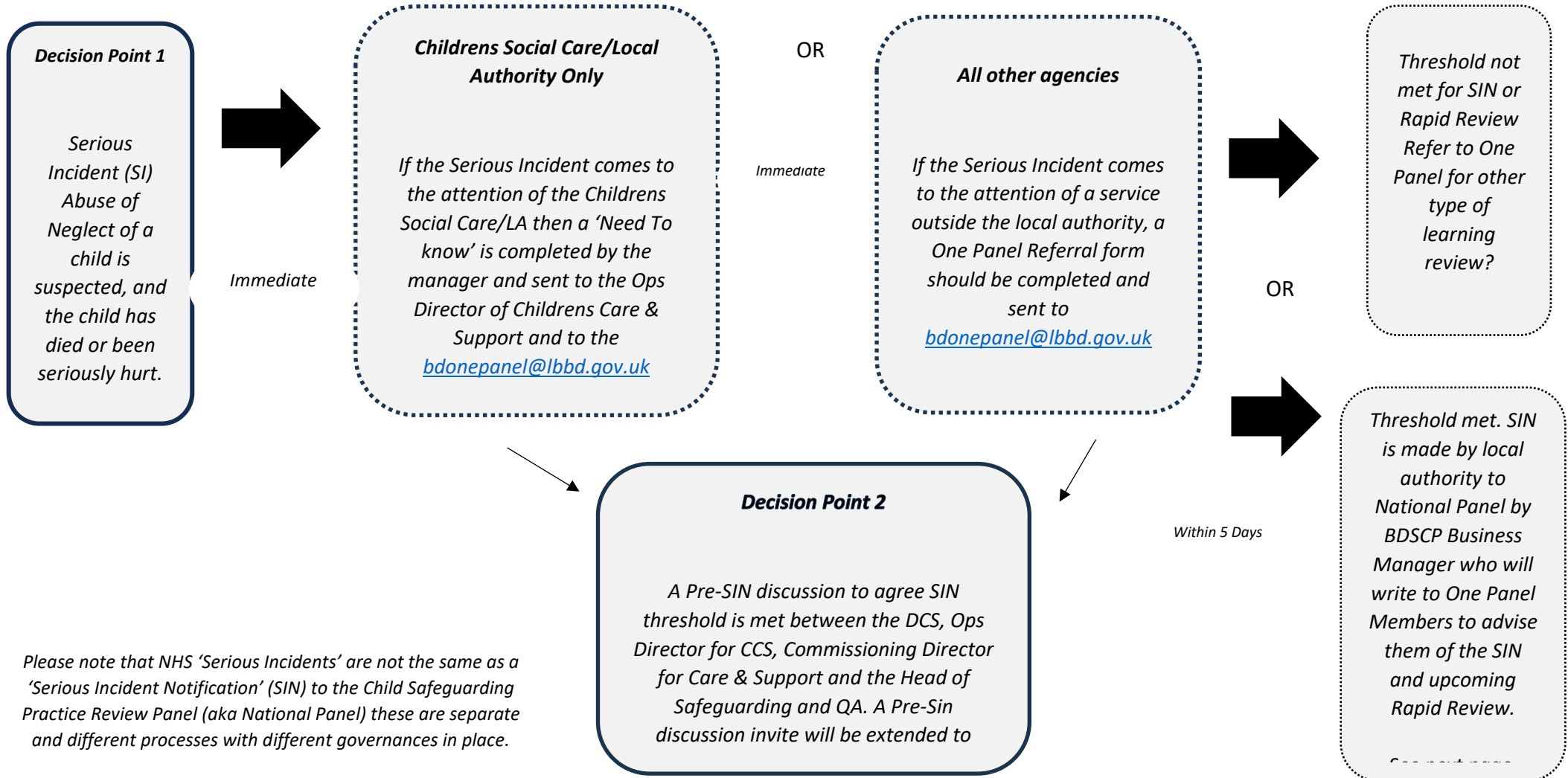
# Level 2 (Breakdown of Routes to One Panel)



# Appendix A

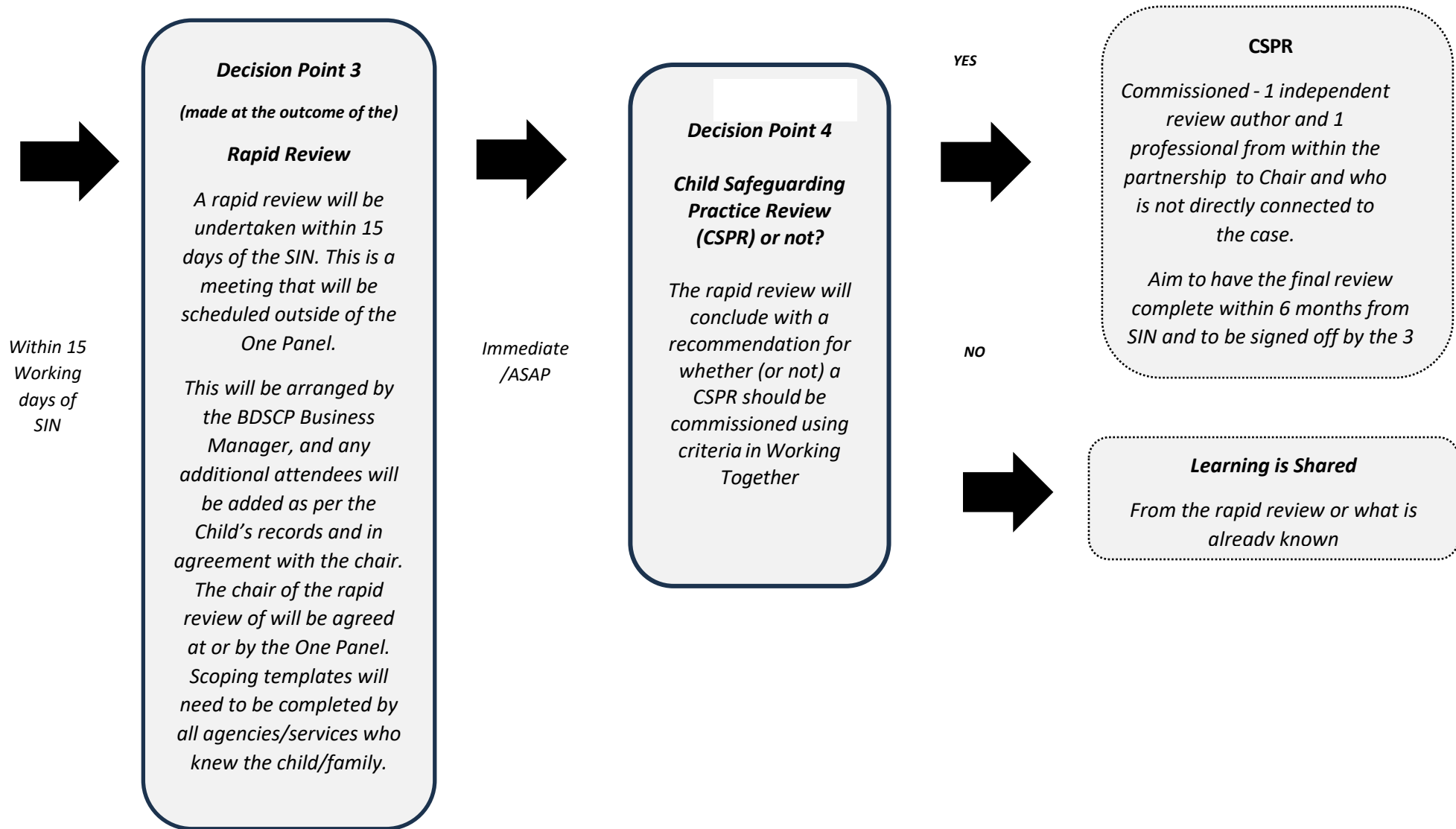
## One Panel process for serious incident notifications and rapid reviews

Incorporates/covers statutory process as described in Working Together 2023 serious incident and serious incident notification.



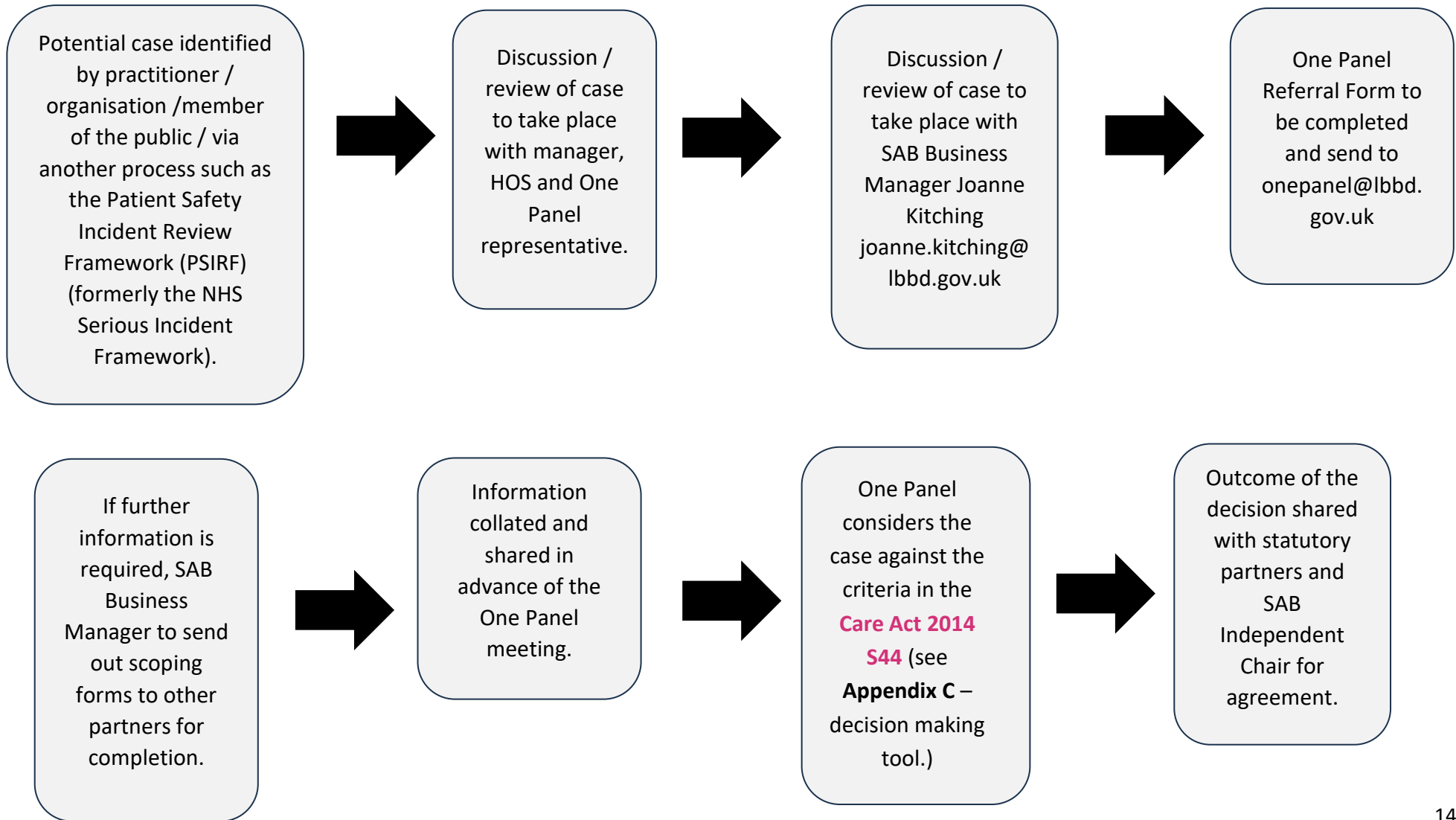
# Appendix A

## One Panel process for serious incident notifications and rapid reviews



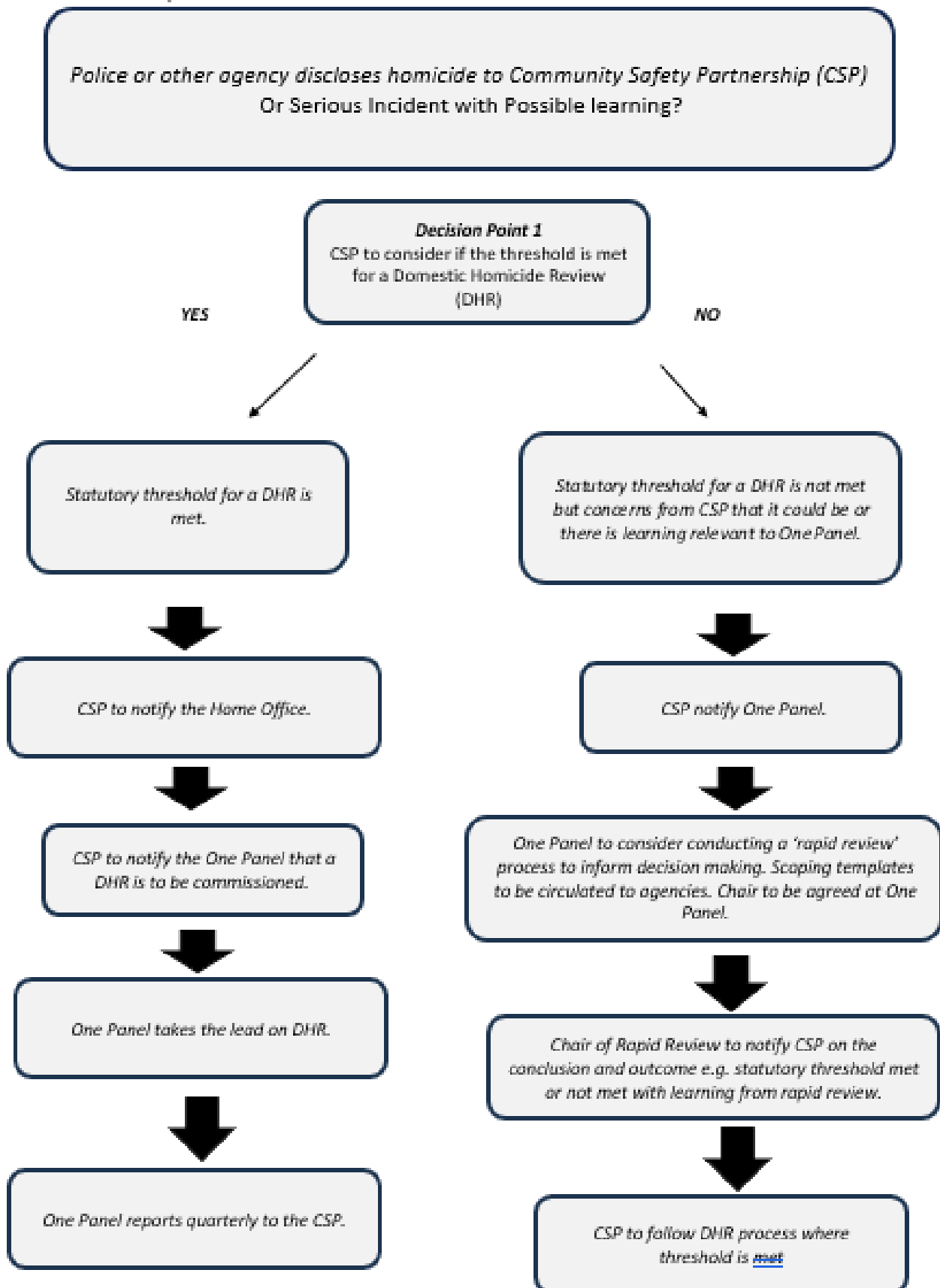
# Appendix A

## One Panel process for Safeguarding Adult Reviews (SARs)



## Appendix A

### One Panel process for domestic homicide reviews



# Appendix B Support Information (Children)

## Rapid Reviews

### [Working Together 2023, Chapter 5](#)

#### Decisions on local and national reviews

336. Safeguarding partners must:

- identify serious child safeguarding cases that raise issues of importance in relation to their area
- commission and oversee the review of those cases if they consider review appropriate

337. When a serious incident becomes known to safeguarding partners, they must consider whether the case meets the criteria and guidance for a local review. If safeguarding partners determine that the criteria is met to undertake a local child safeguarding practice review, then a serious incident notification and rapid review must take place.

**338. In some cases, a 'serious child safeguarding case' may not meet the criteria for a serious incident notification but may nevertheless raise issues of importance to the local area. That might, for example, include where there has been good practice, poor practice or where there have been 'near-miss' incidents. Safeguarding partners may choose to undertake a local child safeguarding practice review in these or other circumstances, in Report a serious child safeguarding incident. This means any person or organisation with statutory or official duties or responsibilities relating to children, Children Act 2004 Section 16F 135 which case they should be clear about their rationale for undertaking such a review and what its focus will be.**

339. It is for safeguarding partners to determine whether a review is appropriate, given that the purpose of a review is to identify improvements to practice. Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review.

340. All incidents should be considered on a case-by-case basis using all information that is available to local safeguarding arrangements. Issues might appear to be the same in some cases, but reasons for actions and behaviours may differ resulting in useful learning for the local area.

341. Decisions on whether to undertake reviews should be made transparently and collaboratively between safeguarding partners, and the rationale recorded and communicated appropriately, including to families. Where there are disagreements, local dispute resolution processes should be followed.

Learning from local reviews should be reflected in the annual reports published yearly by the safeguarding partners. The criteria safeguarding partners must take into account include whether the case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children.
- is one the panel has considered and has concluded a local review may be more appropriate:
- The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018
- Safeguarding partners should also have regard to circumstances where:
- they have cause for concern about the actions of a single agency.
- there has been no agency involvement, and this gives them cause for concern.
- more than one local authority, police area or ICB is involved, including in cases where a family has moved around.
- the case may raise issues related to safeguarding or promoting the welfare of children in institutional settings.



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

- gather the facts about the case, as far as they can be readily established.
- discuss whether any immediate action is 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 undertake a child safeguarding practice review.

As soon as the rapid review is complete, the safeguarding partners should send a copy of their findings to the panel. They should also share with the panel their decision about whether a local child safeguarding practice review is appropriate, or whether they think the case may raise issues that are complex or of national importance such that a national review may be appropriate. They may also do this if, during a local child safeguarding practice review, new information comes to light suggesting that a national review may be appropriate. As soon as they have determined that a local review will be carried out, they should inform the panel, Ofsted and DfE, providing the name of the reviewer they have commissioned.

### **Arranging a Rapid Review in Barking and Dagenham and relation to the One Panel**

**See appendix A** One Panel process for serious incident notifications and rapid reviews on Page 10 of this guidance.

A rapid review will be undertaken within 15 days of the SIN. This is a meeting that will be scheduled outside of the One Panel.

This will be arranged by the BDSCP Business Manager, and any additional attendees will be added as per the Child's records and in agreement with the chair. The chair of the rapid review will be agreed at or by the One Panel. Scoping templates will need to be completed by all agencies/services who knew the child/family.

## **Child Death Reviews**

[Child Death Review \(CDR\)](#) is the process to be followed when responding to, investigating, and reviewing the death of any child under the age of 18, from any cause. It runs from the moment of a child's death to the completion of the review by the Child Death Overview Panel (CDOP). The process is designed to capture the expertise and thoughts of all individuals who have interacted with the case to identify changes that could save the lives of children.

The local arrangements for implementing the Child Death Review (CDR) system have been agreed across Barking and Dagenham, Havering and Redbridge and can be found here:

[Barking and Dagenham, Havering and Redbridge Child Death Review](#) (PDF, 1.52 MB)

In accordance with the statutory guidance [Working Together to Safeguard Children 2023](#) Child death review partners must make arrangements for the analysis of information from all deaths reviewed. The purpose of a review and/or analysis is to identify any matters relating to the death, or deaths, that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in relation to any matters identified. If child death review partners find action should be taken by a person or organisation, they must inform them.

[Statutory guidance for all multi-agency professionals](#) (PDF, 1.3 MB)

## **Notification of a Child Death**

The notification of a child death should be undertaken via completion of Form A on the eCDOP System within 24 hours using the link below:

[BHR eCDOP System](#)

## **Child Death Review Meeting (CDRM)**

This is a multi-professional meeting where all matters relating to an individual child's death are discussed by the professionals directly involved in the care of that child during life and their investigation after death.

## **Child Death Overview Panel (CDOP)**

BHR Child Death Overview Panel (CDOP) is now part of this tri-borough arrangement. The aims of the panel are to: Learn from the deaths of children to help identify ways of preventing future deaths. Identify any improvements that can be made in the services provided to children and their families. Improve the experience of bereaved families and support professionals to care for families effectively. It is a multi-agency panel, set up by the CDOP Manager for BHR (NHS) and attended by the CDR Partners who are senior professionals who would not have provided care for the child during their lifetime which ensures independent scrutiny.

## **Joint Agency Reviews (JAR)**

JAR is a coordinated multi-agency response by the named nurse, police investigator, duty social worker and should be triggered if a child dies:

- is or could be due to external causes;
- is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy/childhood (SUDI/C));
- occurs in custody, or where the child was detained under the Mental Health Act;
- where the initial circumstances raise any suspicions that the death may not have been natural; or
- in the case of a stillbirth where no healthcare professional was in attendance.

All deceased children that meet the criteria for a JAR should be transferred to the nearest appropriate Emergency Department (ED) to enable the JAR to be triggered. A JAR should also be triggered if such children are brought to hospital near death, are successfully resuscitated, but are expected to die in the following days. In such circumstances the JAR should be considered at the point of presentation and not at the moment of death, since this enables an accurate history of events to be taken and, if necessary, a 'scene of collapse' visit to occur.

The "[Sudden and Unexpected Death in Infancy and Childhood: multiagency guidelines for care and investigation \(2016\)](#)" gives comprehensive advice and expectations of all agencies involved in a JAR, and should be applied in full by all agencies. Effective cross-agency working is key to the investigation of such deaths and to supporting the family. It requires all professionals to keep each other informed, to share relevant information between themselves, and to work collaboratively.

## Appendix C

### Domestic Homicide Decision Support Information

#### DHR Statutory Guidance

Domestic Homicide Reviews (DHRs) were introduced in the Domestic Violence, Crime and Victims Act 2004, and came into force in April 2011. A DHR is a process of investigation, re-evaluation, analysing, scrutinising, and making recommendations, by reviewing the circumstances surrounding the **death of a person aged 16 or over which has, or appears to have, resulted from violence, abuse, or neglect by:**

- a person to whom she/he was related or with whom she/he was or had been in an intimate personal relationship, or
- a member of the same household as her/himself, held with a view to identifying the lessons to be learnt from the death.

An 'intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of sex, gender identity or sexual orientation.

A DHR should also be conducted where **the death occurred due to the victim taking their own life (suicide) and the circumstances surrounding the death give rise to concern, such as, where it emerges that there was coercive controlling behaviour in the relationship.**

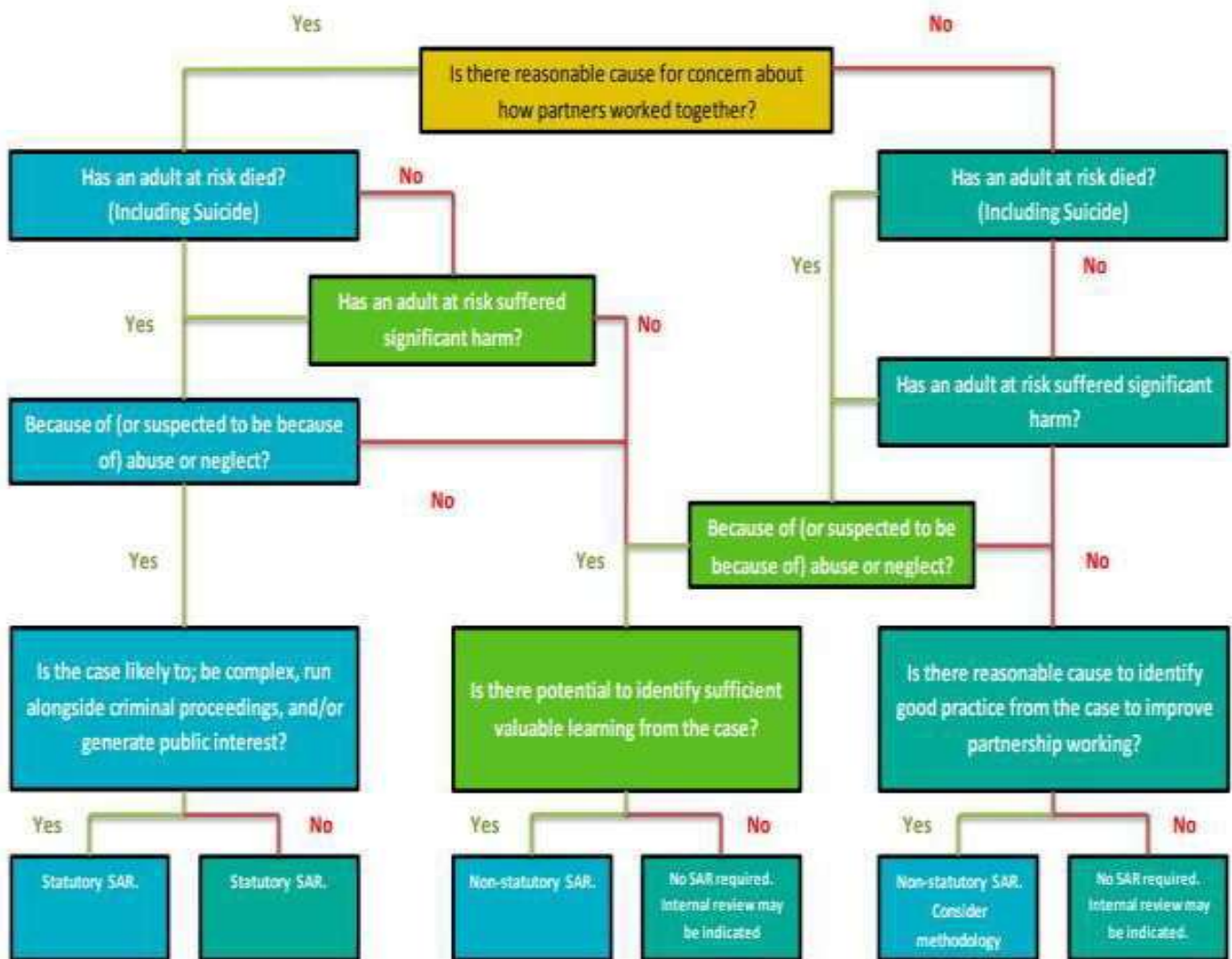
A review should be undertaken, even where a suspect is not charged with a criminal offence, or where they are charged and later acquitted. Where an agency suspects a suicide meets the criteria then they should follow the normal referral process, outlined below. When the definition above has been satisfied, then a DHR should be undertaken.

The Home Office has provided Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, December 2016.

# Appendix D

## Decision Making Tool for Safeguarding Adult Reviews (SAR)

Care Act 2014 ([legislation.gov.uk](http://legislation.gov.uk))



# Appendix E

## Review Methodology Options

|  |   |
|--|---|
| <p><b>Appreciative Inquiry (AI)</b></p> <p>Case reviews conducted as an appreciative inquiry seek to create a safe, respectful, and comfortable environment in which people look together at the interventions that have successfully safeguarded a child; and share honestly about the things they got wrong and/or did not have the desired outcome.</p> <p>It is an opportunity to look at where, how, and why events took place and use their collective hindsight wisdom to design practice improvements.</p> <p>To undertake a case review using the AI principles, the facilitator should be familiar with AI and confident in putting this into practice. AI is facilitated through the use of strength based, solution focused language.</p> <p>AI can be used within any methodology of case review.</p> | <p><b>Benefits of this model are:</b></p> <ul style="list-style-type: none"> <li>• Keeps the child at the centre.</li> <li>• Promotes reflective discussion and enhances critical thinking and analysis.</li> <li>• Enhances the use of structure professional judgement.</li> <li>• It's all about relationships - making a difference through a strengths-based approach.</li> <li>• Encourages professional curiosity.</li> <li>• Embraces and facilitates a learning culture.</li> <li>• Aims to progress timely and meaningful outcomes for children and families.</li> </ul> <p><b>Drawbacks of this model are:</b></p> <ul style="list-style-type: none"> <li>• Potential to ignore or even deny problems.</li> <li>• May lead to over optimistic outcomes.</li> <li>• Potential to not intuitively dig deep enough</li> </ul> |
| <p><b>Reflective Learning Session or multi-agency practitioner events</b></p> <p>Where an independent review is not required, information is gathered from agencies to contribute to a reflective learning session, attended by the relevant professionals to critically appraise the case and learning recommendations agreed.</p>  | <p><b>Benefits of this model are:</b></p> <ul style="list-style-type: none"> <li>• Wide range of professionals involved, including those involved in the case and those not involved in the case.</li> <li>• Proportionate and timely</li> <li>• Allows the referrer to be actively involved in discussion.</li> </ul> <p><b>Drawbacks of this model are:</b></p> <ul style="list-style-type: none"> <li>• Relies on having a robust amount of information prior to, or during discussion to enable the right conclusions to be drawn.</li> <li>• Requires a strong facilitator.</li> </ul>   |

|  |  |
|--|--|
| <p><b>Utilise the Rapid Review approach.</b></p> <p>This is a methodology suitable for use in a number of types of review. It is based on bringing together elements of effective methodologies such as Situational analysis, Signs of Safety, and Kolb’s reflective learning cycle. This model could be used at multi-agency practitioner events, reflective sessions, or rapid and case reviews.</p> <p>The tool provides a structure for practice discussions about individual cases once initial facts are known, for example for a rapid review meeting, practice review discussions or reflective sessions.</p> <p>The purpose of the tool is to guide discussion about specific cases or themes through five stages in a strengths-based way to get from the facts, initial thoughts, and feelings, generating hypotheses and a simple root cause analysis to what needs to happen next in a structured way. It can be used with groups of professionals, or service users.</p> | <p><b>Benefits of this model are:</b></p> <ul style="list-style-type: none"> <li>• Simple to use.</li> <li>• Brings together elements of effective methodologies.</li> <li>• Can be undertaken in a short space of time.</li> <li>• Allows for a balanced focus on what works well and what has not worked well.</li> <li>• Child at the centre</li> <li>• Allows systemic factors to be considered.</li> <li>• Reflects on the whole system approach to keeping the child safe.</li> </ul> <p><b>Drawbacks of this model are:</b></p> <ul style="list-style-type: none"> <li>• New and therefore not yet evaluated as a methodology</li> <li>• Requires participants to display professional curiosity and not be afraid to contribute and challenge.</li> <li>• Requires a strong facilitator</li> </ul> |
| <p><b>Individual Agency Review</b></p> <p>This model would be relevant when a serious incident identifies single agency involvement or where potential one agency learning has been identified.</p> <p>There are no implications or concerns regarding involvement of other agencies, and it is appropriate that lessons are learnt regarding the conduct of an agency.</p>  | <p><b>The benefits of this model are:</b></p> <ul style="list-style-type: none"> <li>• Provides an opportunity for learning from an individual agency.</li> <li>• Enables individual agency scrutiny into a specific area.</li> <li>• Assists a ‘Duty of Candour’.</li> <li>• Supports the sharing of learning to further strengthen a whole system approach to safeguarding.</li> </ul> <p><b>The drawbacks of this model are:</b></p> <ul style="list-style-type: none"> <li>• Can be seen as outside of the purpose of multi-agency learning.</li> <li>• Requires individual agency full buy in and ownership. Risks individual agency opposition.</li> </ul>   |

|   |   |
|---|---|
| <p><b>Multi-agency audits</b></p> <p>Multi-agency audits of case files that relate to a specific theme is an effective mechanism of understanding practice at child level and practitioners and their managers are involved in identifying what they are doing well and where improvements need to be made.</p> <p>A rolling programme of multi-agency audit themes is identified through local priorities, local reviews, inspection findings, performance data and national research.</p>   | <p><b>Benefits of this model are:</b></p> <ul style="list-style-type: none"> <li>• Proportionate</li> <li>• Can utilise multi agency auditors.</li> <li>• General thematic learning which can be consider system wide.</li> </ul> <p><b>Drawbacks of this model are:</b></p> <ul style="list-style-type: none"> <li>• Conclusions from the view point of one or two auditors rather than wholly multi-agency.</li> </ul>  |
| <p><b>Peer review approach</b></p> <p>A peer review approach encompasses a review by one or more people who know the area of business and accords with self- regulation and sector led improvement programme.</p> <p>Peer review methods are used to maintain standards of quality, improve performance, and provide credibility. They provide an opportunity for an objective overview of practice, with potential for alternative approaches and/or recommendations for improved practice.</p> <p>There are two main models for peer review:</p> <ul style="list-style-type: none"> <li>• Peers can be identified from constituent professionals/agencies.</li> <li>• Or peers could be sourced from another area which could be developed as part of regional reciprocal arrangements, which identify and utilise skills and can enhance reflective practice.</li> </ul> | <p><b>The benefits of this model are:</b></p> <ul style="list-style-type: none"> <li>• Increased learning and ownership if peers are from the members.</li> <li>• Objective, independent perspective.</li> <li>• Can be part of reciprocal arrangements across/between partnerships.</li> <li>• Cost effective.</li> </ul> <p><b>The drawbacks of this model are:</b></p> <ul style="list-style-type: none"> <li>• Capacity issues within partner agencies may restrict availability and responsiveness.</li> <li>• Skills and experience issues if reviews are infrequent.</li> <li>• Potential to perceive peer reviews from members of the partnership as not sufficiently independent, especially when they concern political or high-profile cases.</li> </ul> |



## Root Cause Analysis (RCA)

Root Cause Analysis (RCA) is an investigation methodology used to understand why an incident has occurred. RCA provides a way of looking at incidents to understand the causes of why things go wrong. If the contributory factors and causal factors - the root causes - of an incident or outcome are understood, corrective measures can be put in place.

By directing corrective measures at the root cause of a problem (and not just at the symptom of the problem) it is believed that the likelihood of the problem reoccurring will be reduced. This approach can help to prevent unwanted incidents and outcomes, and also improve the quality and safety of services that are provided. The RCA investigation process can help an organisation, or organisations, to develop and open culture where staff can feel supported to report mistakes and problems in the knowledge this will lead to positive change, not blame.

### General principles of Root Cause Analysis:

- RCA is based on the belief that problems are best solved by attempting to correct or eliminate root causes.
- To be effective, RCA must be performed systematically, with conclusions and causes backed up by evidence.
- There is usually more than one potential root cause of a problem.
- To be effective, the root cause analysis & investigation must establish ALL causal relationships between the root cause(s) and the incident, not just the obvious.

### The benefits of this model are:

- The methodology is well known and frequently used in the NHS.
- Focus is on the root cause and not on apportioning blame or fault.
- Effective for single agency issues especially those related to NHS services.

### The drawbacks of this model are:

- Requires skills and knowledge of RCA tools.
- Resource intensive





## Barking and Dagenham

### 'One Panel'

## Referral Form

This referral form is to be used when referring a case for consideration by the Barking and Dagenham 'One Panel' for either a statutory review, i.e., a Safeguarding Adult Review (SAR), Domestic Homicide Review (DHR) or Child Safeguarding Practice Review (CSPR) or when a case may not meet the criteria for a statutory review but there is the opportunity to learn lessons.

Please complete the form below and send to:

[bdonepanel@lbbd.gov.uk](mailto:bdonepanel@lbbd.gov.uk)

Click on the below for the full definition of each:

- [Child Safeguarding Practice Review](#)  
Chapter 5, Working Together 2023
- **Safeguarding Adults Review**  
The Care Act 2014
- **Domestic Homicide Review**

In brief, a statutory SAR or CSPR is when (1) an adult or child has died or been seriously injured and serious abuse or neglect is suspected **and** (2) there is concern about how agencies have worked together to safeguard the child or adult.

A DHR is when the death of a person over the age of 16 years appears to be the result of violence, abuse, or neglect by a (a) a person whom they were related or had an intimate relationship with or  
(b) a member of the same household.

| 1. Context for referral to One Panel |     |
|--------------------------------------|-----|
| Date of this One Panel referral      | / / |
| Summary of reason for referral       |     |
| Date of incident/death               | / / |

| 2. Subject details |  |            |  |                  |  |
|--------------------|--|------------|--|------------------|--|
| First name         |  | Last name  |  | Other names used |  |
| Date of birth      |  | Age        |  | Gender           |  |
| Ethnicity          |  | Disability |  | NHS number       |  |

|              |  |                                   |                  |
|--------------|--|-----------------------------------|------------------|
| GP           |  | Postmortem result (if applicable) |                  |
| Home address |  | Housing tenure                    | School / college |

### 3. Other relevant person(s) details

#### a. Next of kin / nearest relative / nearest relevant person

|                         |  |         |  |
|-------------------------|--|---------|--|
| Name                    |  | DOB     |  |
| Relationship to subject |  | Address |  |

|  |  |
|--|--|
| Any other information that is relevant to the discussion |  |
|--|--|

#### b. Other relevant person / family member / friend

|                         |  |         |  |
|-------------------------|--|---------|--|
| Name                    |  | DOB     |  |
| Relationship to subject |  | Address |  |

|  |  |
|--|--|
| Any other information that is relevant to the discussion |  |
|--|--|

#### c. Other relevant person / family member / friend

|      |  |     |  |
|------|--|-----|--|
| Name |  | DOB |  |
|------|--|-----|--|

|   |  |                |  |
|---|--|----------------|--|
| <b>Relationship to subject</b>                                  |  | <b>Address</b> |  |
| <b>Any other information that is relevant to the discussion</b> |  |                |  |
| <i>Please add others as required</i>                            |  |                |  |

**4. Agency involvement with the subject and relevant others** Brief summary of work/intervention undertaken. Please include the key points, an analysis that summarises and gives the case outline. Do not include a full chronology at this stage.

|   |  |
|---|--|
| <p><b>Details of Original Referrer/Referral</b></p>   |  |
| <p><b>Summary of case/circumstances</b></p>   |  |
| <p><b>Agencies involved with the Service User</b></p>   |  |
| <p><b>Summary of agency involvement, intervention, care and service provision including any safeguarding concerns raised, Section 42s, DoLs, Child Protection Plan, looked after child etc.</b></p> |  |
| <p><b>Summary of potential themes/challenges/learning identified that support the referral.</b></p>   |  |
| <p><b>How well, in your opinion, has the multi-agency partnership worked together?</b></p>  |  |

| 5. Referrer details   |  |                |  |
|---|--|----------------|--|
| <b>Name</b>   |  | <b>Agency</b>  |  |
| <b>Role</b>   |  | <b>Contact</b> |  |
| <b>Manager Name responsible for quality assuring the referral</b>   |  |                |  |
| <b>Is this referral subject to an internal/single agency review?</b>  |  |                |  |
| <b>Lessons learnt:</b> <i>If appropriate please describe the lessons that have been learnt by your agency and any changes made as a result.</i> |  |                |  |
| <b>Considerations:</b> <i>For example, is there media interest? Are there criminal proceedings? Is the case linked to a complex abuse case?</i> |  |                |  |

| 6. One Panel Decision <i>(to be completed by One Panel Secretariat following meeting)</i> |     |                          |  |
|---|-----|--------------------------|--|
| <b>Meeting Date</b>   | / / | <b>OP recommendation</b> |  |
| <b>Follow up action</b>   |     |                          |  |