

## **Learning Reviews**

The Safeguarding Board will conduct learning Reviews in respect of both children and vulnerable adults. The Board will also undertake partnership reviews into cases that do not meet the criteria for a learning review, but can identify learning as to the way organisations can work together to safeguard and protect the welfare of children and adults; reviews into good practice may also be undertaken.

Any Department, agency (or service user or the Coroner) should notify the Safeguarding Board of any cases they consider meets the criteria for a Learning Review.

The decision to undertake a Learning Review rests with the Chair of the Safeguarding Board.

## **Learning Review Criteria**

Learning Reviews will be conducted in accordance with the following criteria.

The criteria for undertaking a Learning Review in respect of a child are:

- a. Abuse or neglect of a child is known or suspected; and
- b. Either (i) the child has died (including by suspected suicide); or (ii) the child has been seriously harmed; and
- c. There is cause for concern as to the way in which the Safeguarding Board, partners or other relevant bodies have worked together to safeguard the child.

Cases which meet one of the above criteria must always trigger a Learning Review. Where a case is being considered under (b)(ii), unless there is definitive evidence that there are no concerns about inter-agency working, the Safeguarding Board must commission a Learning Review.

In addition, even if one of the criteria is not met, a Learning Review should always be carried out when a child dies in custody, in police custody, on remand or following sentencing. The same applies where a child dies who was detained under the Mental Health & Mental Capacity Ordinance 2015.

The criteria for undertaking a Learning Review in respect of an adult are:

- a. an adult who is entitled to services, whether they are in receipt of them or not, dies (including death by suicide) and abuse or neglect is known or suspected; or
- b. an adult has suffered serious harm: and
- c. there is cause for concern as to the way in which the Safeguarding Board partners or other relevant bodies have worked together to safeguard the adult.

Cases which meet the above criteria must always trigger a Learning Review.

The Safeguarding Board must conduct a review of the involvement of the Department, other agencies and professionals, in the events leading up to the death or the harm.

In respect of both adult and children's Learning Reviews the Chair of the Safeguarding Board needs to determine that there is significant learning to be gained from the review which, if applied effectively, will lead to substantial improvements in practice in safeguarding and promoting the welfare of children and vulnerable adults in St. Helena.

In respect of both children and adults, if serious harm takes place in an institution or when multiple abusers are involved, the same principles of review apply. Such reviews are, however, likely to be more complex, on a larger scale, and may require more time. Terms of reference need to be carefully constructed to explore the issues relevant to each specific case and must include specific reference to timing of the review.

"Serious harm" in the context of the above includes, but is not limited to, cases where the child or adult has sustained, as a result of abuse or neglect, any or all of the following:

- a. The child or the adult has died or suffered a potentially life-threatening injury; this could include serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

This definition is not exhaustive. In addition, even if a child or an adult recover, this does not mean that serious harm cannot have occurred. The Safeguarding Board must ensure that their considerations on whether serious harm has occurred are informed by available research evidence.

## **Principles and Best Practice**

The Safeguarding Board, in undertaking Learning Reviews, will apply clear principles and best practice standards.

The approach taken to Learning Reviews will be proportionate, according to the scale and level of complexity of the issues being examined; a variety of different models may be used.

The child or adult should remain at the centre of the process.

An independent person with relevant skills and experience will always be contracted by the Safeguarding Board, to act as the Independent Overview Author.

An independent person will chair the Learning Review Panel established to oversee the review. The person may be a member of the Safeguarding Board, providing they have had no previous involvement in the case being reviewed.

Learning Reviews will be led by experienced managers who are independent of the services being reviewed; they may or may not be a member of the Safeguarding Board.

If required by the Safeguarding Board, all member organisations will identify individuals who are operationally independent of the case under review and have professional knowledge of the area under review, to complete Individual Management Reports or other information reports of their agencies involvement, to inform the Overview Report.

Learning Reviews will make use of relevant research and case evidence to inform the findings and will seek to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight; they will describe why practice, both good and in need of improvement occurred.

Practitioners must be fully involved in reviews and reviews must recognise the complex circumstances in which professionals work together to safeguard children and adults; and the procedures in operation at the time of the incidents that led to the review.

Families, including surviving children, should be invited to contribute to reviews; they should be informed how they are going to be involved and have their expectations managed appropriately and sensitively.

Learning Reviews will take note of other processes which are being carried out, for example a Coroner's Inquest or a Police investigation, as this may necessitate the review being temporarily suspended.

Learning reviews or the outcomes of reviews will NOT be published due to issues of confidentiality.

The summary and actions arising from the learning reviews will tracked via the safeguarding board, but will NOT be made public.

The subjects of the review and individual professionals involved in the case and their organisations must be provided with appropriate feedback on the outcome of the reviews.

Improvement must be sustained through regular monitoring and audit so that the findings from these reviews make a real impact on improving outcomes for children and adults.

Reviews of good practice will also be undertaken to improve knowledge of what works well.

## **Review Process**

The procedure of how to notify cases for consideration for a Learning Review and other review processes can be obtained by contacting the Safeguarding Board.