Redbridge

‘One Panel’:

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

Version 1.3

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1. Purpose of the One Panel

The 'One Panel' is a multi-agency group which receives referrals on cases in Redbridge that may meet statutory review criteria, such as a Safeguarding Adults Review (SARs), Child Safeguarding Practice Reviews (CSPRs)[1] or Domestic Homicide Reviews (DHRs). The purpose of the Panel is to provide a multi-agency decision making forums 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.

2. Membership

The Panel will be chaired by the Associate Director Safeguarding Adults/Associate Director Safeguarding Children, North East London (NEL) NHS Integrated Care System (ICS). Membership will consist of senior officers from agencies members from the following agencies:

Role	Organisation
Head of Service, HASS/Principal Social Worker (PSW)	LB Redbridge
Strategic Lead – Safeguarding and Professional Practice (Adults)	LB Redbridge
Integrated Care Director	NELFT
Assistant Director Children & Families	LB Redbridge
Assistant Director Corporate Parenting & Principal Child and Family Social Worker (PCFSW)	LB Redbridge
Designated Professional Safeguarding Children	North East London NHS ICS
Designated Professional Safeguarding Adults	NEL NHS ICS
Detective Chief Inspector – Partnerships Lead	East Area (EA) Basic Command Unit (BCU), MPS
Named Professional Safeguarding Children	Barking, Havering, and Redbridge University Trust (BHRUT)
Named Professional Safeguarding Adults	BHRUT
Named Professional Safeguarding Children	Bart's Health NHS Trust
Named Professional Safeguarding Adults	Bart's Health NHS Trust

[1] See appendix E

Named Professional Safeguarding Children	NELFT
Named Professional Safeguarding Adults	NELFT
Head of Community Safety/Senior Community Safety Officer	Redbridge Community Safety Partnership
Solicitor – Legal Services	LB Redbridge
Area Manager	National Probation Service
Head of Housing Management Service	LB Redbridge
Strategic Commissioner Public Health	LB Redbridge

Additional agencies may be asked to attend where relevant to the case including out of Borough representatives.

3. Panel Meetings

The Panel will meet monthly. A Panel meeting can be cancelled by the Chair if there are no new referrals and no requirement for critical decisions 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.

4. Governance

This responsibility for screening cases has been delegated to the Panel by the Redbridge Safeguarding Adults Board (RSAB), the Redbridge Safeguarding Children Partnership (RSCP) and the Redbridge 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.

Should any members of the 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 rationale 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 Panel Chair. The Panel Chair will consider if the Panel needs to reconvene to review the decision or raise with the Chairs of the RSCP, RSAB and CSP and the lead agencies for the final decision.

5. Roles and Responsibilities

The Panel Chair will:

- be one of the statutory safeguarding partners, agreed by the joint RSCP and RSAB Executive;

- rotate on a yearly basis;
- report to the RSCP, RSAB and Redbridge Community Safety Partnership annually;
- provide updates on individual case reviews as appropriate.
- Be supported by the RSAB, RSCP 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

6. Process

When a professional believes that the criteria has been met on a case for DHR or SAR, relevant referral form is completed and submitted to the Panel Secretariat. In the case of children, the outcome of the multiagency meeting to the make the decision on whether the criteria for a Serious Incident Notification and any subsequent Rapid Review (RR) (see **Appendix E**) 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.

The Panel Secretariat will review the referral and go back to the referrer if any further information is required.

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 B**

and **Appendix C**). 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 Secretariat, 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.

7. 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 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 – The initial screening and decision to make a Serious Incident Notification and undertake a Rapid Review (RR) is the responsibility of the leads for the statutory safeguarding partners (see **Appendix A**) who should convene a 'virtual' panel (see separate guidance). If the decision is reached that the referral does not meet criteria for a RR, the information is shared with the One Panel to consider if there is any learning from the referral and how this may be undertaken.

Methodology options can be utilised to support suitable and proportionate learning (see **Appendix D**).

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 manged via the local CSPR Panel formed to oversee the case.

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 RSCP 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 RSCP.

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 C** 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 D** 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 manged 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 RSAB 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 RSAB.

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 B**. 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 D methodology options can be utilised to support suitable and proportionate learning.

The outcome of the screening must be shared with the Community Safety Partnership (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.

8. Commissioning Reviews

As well as making a recommendation to the statutory safeguarding partners on the type of review, the Panel will also make recommendations in relation to the focus and methodology. The RSAB, RSCP and CSP will be responsible for commissioning the review, including identification of independent reviewer.

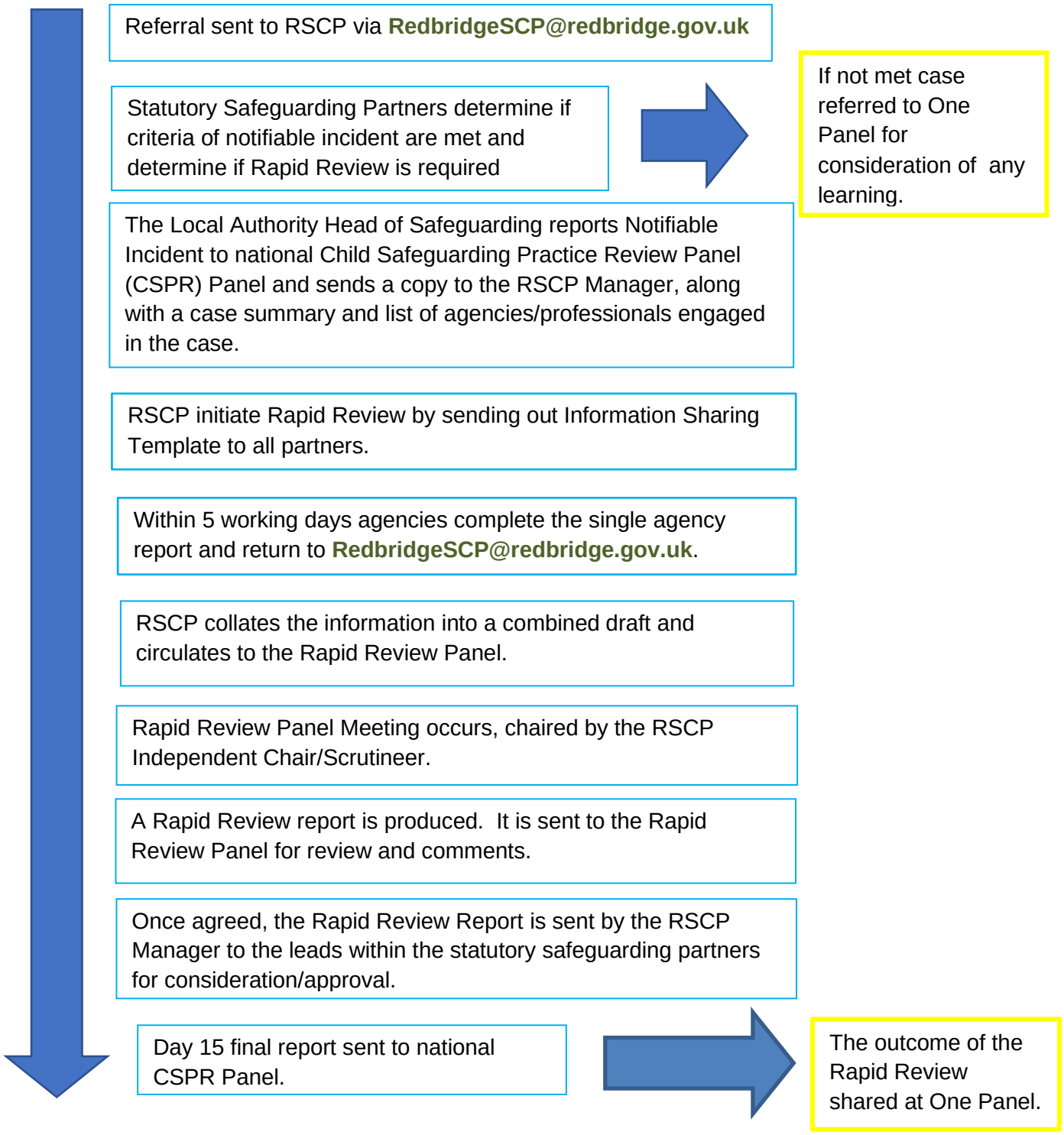
9. Review of the One Panel

The One Panel and this guidance will be reviewed annually or as appropriate if there are changes in statutory guidance.

Appendix A

Pathways for Statutory Process to One Panel - Children

Processes for review outlined in **Working Together to Safeguard Children 2023** statutory guidance from referral to submission the Rapid Review to the National Panel need to be concluded in 15 working days an occurs outside of the One Panel.



Pathways for Statutory Process to One Panel - Adults

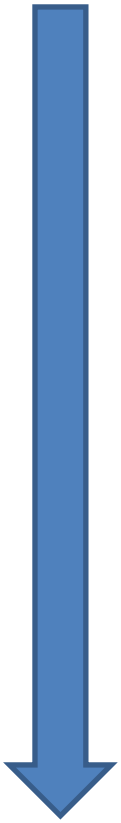
Case for learning identified by an individual professional/practitioner/volunteer and referred to RSAB vial: **RSAB@redbridge.gov.uk** .

SAB Business Manager send out screening request for information to all partners to be completed in 10 working days.

Information collated and shared in advance of the next One Panel meeting.

One Panel considers the case against the criteria in the **Care Act 2014 S44** (see **Appendix C** – decision making tool.)

Outcome of the decision shared with Statutory partners and RSAB Independent Chair for agreement.



Pathways for Statutory Process to One Panel - Domestic Homicide

Police or other agency discloses homicide to CSP.

Community Safety Partnership (CSP) request screening information and agenda for One Panel and add to next meeting agenda.

One Panel decide if criteria to hold a Domestic Homicide Review (DHR) is met using the guidance or alternative learning methodology or review process.

Outcome shared with CSP.

CSP inform the Home Office of decision to hold DHR or not.

Domestic Homicide Decision Support Information

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**.

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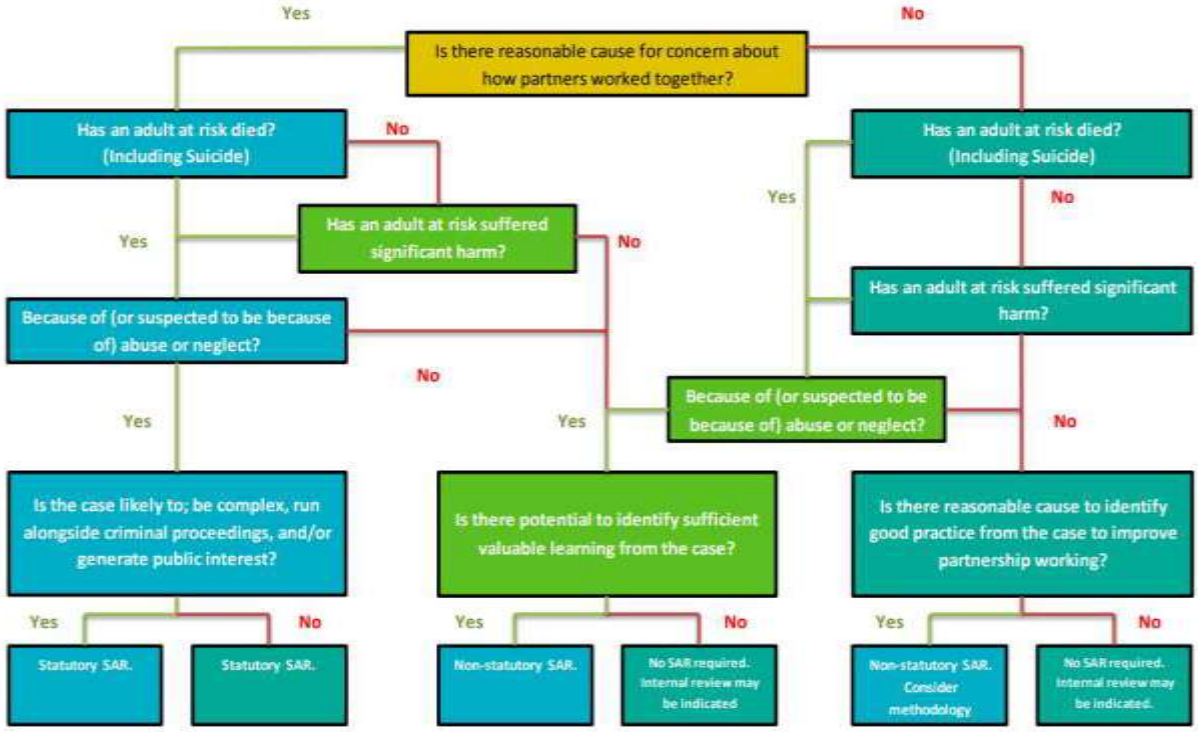
Appendix C

Decision making tool for Safeguarding Adult Reviews (SARs)



Appendix D

Review Methodology Options

Appreciative Inquiry (AI) 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. It is an opportunity to look at where, how, and why events took place and use their collective hindsight wisdom to design practice improvements. 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. AI can be used within any methodology of case review.	**Benefits of this model are:** • Keeps the child at the centre • Promotes reflective discussion and enhances critical thinking and analysis • Enhances the use of structure professional judgement • It's all about relationships - making a difference through a strengths-based approach • Encourages professional curiosity • Embraces and facilitates a learning culture • Aims to progress timely and meaningful outcomes for children and families **Drawbacks of this model are:** • Potential to ignores or even deny problems • May lead to over optimistic outcomes • Potential to not intuitively dig deep enough
Reflective Learning Session or multi-agency practitioner events 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.	**Benefits of this model are:** • Wide range of professionals involved, including those involved in the case and those not involved in the case. • Proportionate and timely • Allows the referrer to be actively involved in discussion **Drawbacks of this model are:** • Relies on having a robust amount of information prior to, or during discussion to enable the right conclusions to be drawn. • Requires a strong facilitator
Utilise the Rapid Review approach 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. 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.	**Benefits of this model are:** • Simple to use • Brings together elements of effective methodologies • Can be undertaken in a short space of time • Allows for a balanced focus on what works well and what has not worked well. • Child at the centre • Allows systemic factors to be considered • Reflects on the whole system approach to keeping the child safe. **Drawbacks of this model are:** • New and therefore not yet evaluated as a methodology

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.	• Requires participants to display professional curiosity and not be afraid to contribute and challenge • Requires a strong facilitator
Individual Agency Review This model would be relevant when a serious incident identifies single agency involvement or where potential one agency learning has been identified. 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.	**The benefits of this model are:** • Provides an opportunity for learning from an individual agency. • Enables individual agency scrutiny into a specific area. • Assists a 'Duty of Candour'. • Supports the sharing of learning to further strengthen a whole system approach to safeguarding **The drawbacks of this model are:** • Can be seen as outside of the purpose of multi-agency learning. • Requires individual agency full buy in and ownership. Risks individual agency opposition.
Multi-agency audits 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. A rolling programme of multi-agency audit themes is identified through local priorities, local reviews, inspection findings, performance data and national research.	**Benefits of this model are:** • Proportionate • Can utilise multi agency auditors • General thematic learning which can be consider system wide **Drawbacks of this model are:** • Conclusions from the view point of one or two auditors rather than wholly multi-agency.
Peer review approach 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. 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	**The benefits of this model are:** • Increased learning and ownership if peers are from the members. • Objective, independent perspective. • Can be part of reciprocal arrangements across/between partnerships. • Cost effective. **The drawbacks of this model are:** • Capacity issues within partner agencies may restrict availability and responsiveness. • Skills and experience issues if reviews are infrequent.

improved practice. There are two main models for peer review: • Peers can be identified from constituent professionals/agencies • 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.	• Potential to perceive peer reviews from members of the partnership as not sufficiently independent, especially when they concern political or high-profile cases.
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

Redbridge 'One Panel' Case Referral Form

This referral form is to be used when referring a case for consideration by the Redbridge '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: **RedbridgeOnePanel@redbridge.gov.uk**

Click on the below for the full definition of each:

- **Child Safeguarding Practice Review**
  Chapter 4, Working Together 2018
- **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 serious 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**		
Relationship to subject			**Address**		
Any other information that is relevant to the discussion					
Please add others as required					

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.	
Details of original referral/contact with agency	*Subject:*
	Others:
Status i.e., subject of a CP plan, looked after child, subject to adult at risk procedure, subject to deprivation of liberty safeguards (DoLS) etc.	*Subject:*
	Others:
Summary of work/intervention and analysis that illustrates the case outline	*Subject:*
	Others:
What other agencies have been involved with the family?	*Subject:*
	Others:

How well, in your opinion, has the multi-agency partnership worked together?	

5. Referrer details			
Name		**Agency**	
Role		**Contact**	*Tel no. / email*
Manager Name responsible for quality assuring the referral			
Is this referral subject to an internal/single agency review?			
Lessons learnt: *If appropriate please describe the lessons that have been learnt by your agency and any changes made as a result.*			
Considerations: *For example, is there media interest? Are there criminal proceedings? Is the case linked to a complex abuse case?*			

6. One Panel Decision *(to be completed by One Panel Secretariat following meeting)*			
Meeting Date	***/ /***	**OP recommendation**	
Follow up action			

Guidance for 'virtual' panel on review of referrals to the Redbridge 'One Panel' relating to a child under 18 years or a Care leaver up to the age of 24

On receipt of a referral to the Redbridge 'One Panel' mail box relating to a child a 'virtual' panel, made up of representatives from the Statutory Safeguarding Partners at Executive level will be convened.

The purpose of the 'virtual' panel is to consider the referral against the criteria for Serious Incident Notification and Rapid Review using this guidance. If the criteria is not met the case will be passed to the one panel for consideration of other learning processes that may be more appropriate.

The Panel will consider whether a serious incident notification needs to be made to national Child Safeguarding Practice Review (CSPR) Panel.

To reach a decision, the 'virtual' Panel members will:

1. Review the referral

2. Identify if their own agency holds further information to inform the decision making

3. Consider whether the criteria for Serious Incident Notification have been met and so warrants a notification to the national CSPR Panel.

4. Consider whether a Rapid Review is required

5. Ensure a clear rationale for the decision is documented and shared with the Chair of the Redbridge 'One Panel'.

6. If the 'One Panel' identify additional information that changes this, they utilise the escalation process outlined in the 'One Panel' guidance

What are the criteria for a Serious Child Safeguarding Case?

Serious Child Safeguarding cases are those in which:

- abuse or neglect is known or suspected and
- the child has died or been seriously harmed

Serious Harm is defined as serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list.

When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.

Panel members should reflect on how the case referred is ***distinct from other Child Protection*** *cases* because of the level of harm being seen. See the Child Safeguarding

Practice Review Panel guidance for safeguarding partners (September 2022) for additional support.

What are the criteria for a Serious Incident Notification to National CSPR Panel?

If the above criteria for Serious Child Safeguarding case have been met, then the Local Authority must notify the national CSPR Panel within five working days of becoming aware that the incident has occurred. The Local Authority must also notify the Secretary of State and Ofsted where a child looked after has died, whether or not abuse or neglect is known or suspected.

The local authority should also notify the Secretary of State for Education and Ofsted of the death of a care leaver up to and including the age of 24. The Local Authority has a specific pathway for this Notification. This should be notified via the Child Safeguarding Online Notification System. The death of a care leaver does not require a rapid review or local child safeguarding practice review. However, safeguarding partners must consider whether the criteria for a serious incident have been met and respond accordingly, in the event the deceased care leaver was under the age of 18. If local partners think that learning can be gained from the death of a looked after child or care leaver in circumstances where those criteria do not apply, they may wish to undertake a local CSPR. In Redbridge the case can be referred to the 'One Panel' for consideration.

The Panel must consider the following guidance when making their decision:

1. Does the case highlight or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified?

2. Does the case highlight or may highlight recurrent themes in the safeguarding and promotion of the welfare of children?

3. Does the case highlight or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children?

The Panel should also have regard to the following circumstances:

1. Where the safeguarding partners have cause for concern about the actions of a single agency.

2. Where there has been no agency involvement, and this gives safeguarding partners cause for concern as to why?

3. Where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.