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Learning Review Guidance

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**Learning Review Guidance**

1. **Introduction**
   1. Tower Hamlets & City of London Youth Justice Service (YJS) is unwavering in our commitment to being a learning organisation that actively fosters a culture of continuous learning and development. This includes reflecting upon and harnessing learning from serious incidents of a community safeguarding and public protection nature involving children in the criminal justice system. By doing so, we aim to reduce the likelihood of serious incidents of a similar nature reoccurring and most importantly safeguard children and members of the public from significant harm.
2. **Who is this guidance for?**
   1. It’s for everyone. This includes the YJS and multi-agency partners who may be involved in participating in learning review processes. It’s essential that all learning reviews take account of the interplay with any multi-agency partners and does not solely focus on the role and work of the YJS.
3. **What is the purpose of this guidance?**
   1. To provide a clear and collectively understood approach to learning reviews in response to serious incidents related to community safeguarding and public protection incidents involving Tower Hamlets and City of London children in the criminal justice system.
   2. The desired outcome is that this guidance helps to create the conditions for systematically extracting learning from serious incidents, identifies good practice as well as directly impacting upon changes to practice and service delivery where needed all of which being disseminated to the workforce and partnership as necessary.
   3. This guidance should be read in conjunction with:

* [Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/media/65803fe31c0c2a000d18cf40/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf)
* Multi-agency public protection arrangements (MAPPA): Guidance - GOV.UK (www.gov.uk)
* <https://proceduresonline.com/trixcms/media/8056/thc-yjs-management-of-risk-of-serious-harm-to-others-policy.doc>
* [Case management guidance - Guidance - GOV.UK (www.gov.uk)](https://www.gov.uk/guidance/case-management-guidance)

1. **Approach to Learning Reviews**
   1. First and foremost, this is not about proportioning blame to any individual(s) or organisation(s). It is rooted in identifying and applying learning for the future. Learning reviews are not conducted to hold individuals or organisations to account as there are other processes for that purpose.
   2. At the core of our approach to learning from serious incidents is one which places the lived experience of the child at the centre. This forms part of a ‘Child First’ approach which is open to constructive challenge so that the YJS and wider partnership can take positive action(s) from serious incidents as part of delivering improved services for children which effectively safeguards children and the public.

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* 1. The approach to Learning Reviews is underpinned by our homegrown ‘Better Together’ practice framework developed in collaboration with our staff. It utilises the 6 ‘C-Change’ principles to guide the Learning review process. Whilst this is the practice framework for the Supporting Families division the ethos is equally applicable to our multi-agency partners.

1. **Connect:** Utilising a relational approach, our learning reviews are undertaken collaboratively in a group setting rather than produced in silos.
2. **Curious:** Exploring every possible indicator of what may have contributed towards a serious incident occurring and trying to understand what the life of a child is like on a day-to-day basis. We all carry a level of unconscious bias and our own culture can impact upon perceptions. As such, the relational and group approach to learning reviews seeks to create the conditions for respectful professional curiosity.
3. **Community:** Including the professional team around the child in the learning review process as part of seeking to reduce the likelihood of creating a ‘single story’ about what happened and the possible reasons for this. Many stories matter in the learning review process.
4. **Co-produce:** Once the learning has been extracted it’s crucial that a plan is co-produced with participants to harness and disseminate good practice and learning.
5. **Collaborate:** As part of implementing change, it will be important that all participants from within the Supporting Families division and across the multi-agency network implement the identified actions relevant to their practice, service and organisation.
6. **Check Back:** A timescale for reviewing progress in applying the learning should be set where the multi-agency group re-convenes.
7. **Aim of Learning Review**
   1. The overall aims of learning reviews in response to serious incidents of a community safeguarding and public protection nature are:

* To improve the safeguarding of children where possible within Tower Hamlets and City of London through review of local practice, procedures and processes across the Supporting Families division and multi-agency partnership;
* To support the delivery of high-quality services through identification of areas for improvement and;
* To identify areas of good practice and partnership working;

1. **Learning Review Criteria**
   1. A serious incident notification as per the Youth Justice Board (YJB) [Serious incidents notification: standard operating procedures for YJSs - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/serious-incidents-notification-standard-operating-procedures-for-yots/serious-incidents-notification-standard-operating-procedures-for-yots) which is outlined below is the trigger point for the learning review process to be initiated. There may also be other incidents of concern identified via the ‘need to know’ notification to Heads of Service & Director (Supporting Families Division) reviewed via the YJS Risk Management & Resource Panel which may result in a learning review.

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| Serious Incidents | |
| **Safeguarding Criteria**  *This applies to children who are currently open to YJS or whose order/intervention has closed within the last 20 days.* | **Youth Justice Board Criteria**  *This applies to children who are currently open to YJS or whose order/intervention has closed within the last 20 days.* |
| Child Dies (this would fall within the remit of a Child Safeguarding Practice Review via Tower Hamlets Safeguarding Children’s Partnership) | Attempted murder |
| Attempts suicide | Murder/Manslaughter |
| Victim of a rape (where an allegation has been made to police) | Rape |
| Has sustained a potentially life-threatening injury | Grievous bodily harm or wounding with or without intent – section 18/20 |
| Has sustained serious and permanent impairment of Health or/& Development | Terrorism related offence |

1. **Learning Review Categories**
   1. There are two types and stages of learning reviews as outlined below:

**Initial Learning Review (ILR)**

* 1. This is the first step of the learning review process. Initial Learning Reviews (ILR) provide a crucial opportunity to promptly capture immediate learning in response to a serious incident so that key information, critical issues and lessons can be captured as well as any necessary action taken.
  2. The mechanism for doing so is via the YJS Risk Management & Resource Panel and is chaired by the Head of Service for Youth Justice. This should ideally take place at the next scheduled panel following the YJS becoming aware of the incident. This initial review is important as the wider learning review process can be a lengthier process.
  3. The Head of Service for Youth Justice will co-chair the initial learning review alongside either the Head of Service for Safeguarding & Quality Assurance and/or the Head of Learning Academy. In attendance will also be the core members of the YJS Risk Management & Resource Panel as well as any other multi-agency partners identified.
  4. An action plan is produced with a focus on addressing immediate risk management and safeguarding concerns identified. As part of the action plan a decision will be made by the Head of Service for Youth Justice, Head of Service for Safeguarding & Quality Assurance and/or the Head of Learning Academy about whether a full-learning review should be undertaken.

**Full Learning Review (FLR)**

* 1. This is the second step of the learning review process and is conducted as a learning workshop as well as decision-making forum.
  2. Full Learning Reviews (FLR) provide an opportunity to undertake a deeper and systematic approach in response to the serious incident. This should ideally be completed within 3 months.
  3. The mechanism for the end-to-end coordination of the full learning review is via the Supporting Families strategic group for quality assurance led by the Head of Learning Academy. This will also be the forum for identifying representatives from internal services to participate in the learning review (e.g. youth justice service, children’s social care and early help etc).
  4. The Head of Service for Youth Justice will co-chair the full learning review alongside either the Head of Service for Safeguarding & Quality Assurance and/or the Head of Learning Academy.

1. **Which YJS should complete a learning review?**
   1. The YJS supervising a child at the time of the incident should lead on undertaking the learning review. In the event where there may be more than one YJS involved with the child, the learning review should be completed by the YJS with day-today management of the case. However, the home YJS should be actively involved in the learning review.
   2. Where a serious incident relates to a child we care for and is placed outside Tower Hamlets or City of London the local authority who is the corporate parent should be fully involved in drawing together any lessons learned.
2. **Considerations as part of the Learning Review process**
   1. The following is not a prescriptive guide of what must be focussed on as part of the Learning Review process however is intended to provide guidance.

**Diversity & Disproportionality**

* 1. Consideration should be given to children and families diversity factors including how well these have been understood and services deliberately personalised to meet their needs. This includes actual or potential discriminatory factors where they exist. This enables us to see the diversity needs in the wider context of children’s experiences as well as pulling out any diversity specific learning and recommendations in the context of the learning review.
  2. These are defined as:
* **Protected Characteristics:** We define these as those set out in the [Equality Act 2010: guidance - GOV.UK (www.gov.uk)](https://www.gov.uk/guidance/equality-act-2010-guidance). These are care experienced children, race, age, disability, gender, sexuality, gender reassignment, pregnancy and maternity, marriage or civil partnership and religion or belief.
* **Personal Circumstance:** We define these as individual’s personal circumstances that could impact children and family’s ability and capacity to engage with services as well as how well the youth justice service and associated multi-agency partners meets any needs arising from these. For example, maturity, learning needs, mental health, cultural identity and a child who attends education/training/employment or is a carer might need flexible arrangements.
* **Disproportionality:** We define this as the ability to consider and address matters related to disproportionality which is amplified at every stage of the criminal justice system. This results in the overrepresentation of children from global majority backgrounds. This aims to contribute towards reducing racial disparities of children in the criminal justice system as well as discrimination more broadly.

**Child’s Behaviour & Lived Experience**

* 1. To reflect on any factors in the child’s life that could have helped to predict that the incident might occur. Where a risk of harm had previously been identified to consider what was in place to manage the risk and protect the child and/or the public. A concise summary of factors in the child’s life that could help to predict that the incident might occur is best, for example their experience of abuse, self-harm and use of drugs and alcohol.
  2. Understanding the relevant aspects of the child’s experiences should be taken into consideration, including their experience in care, being a victim of child exploitation and the child’s vulnerability. All of which needed to be drawn upon to give a full picture of the child’s life and what may have predisposed them to such behaviour.

**Voice of Child**

* 1. As part of the learning review, it’s important that the lead from either the youth justice service or children’s social care meets with the child. When reviewing incidents, it’s important to give children involved an opportunity to share their views about what happened and to work with them to identify and put in place the support and protective factors that will help keep them safe and prevent future incidents. Whilst this is the aspiration consideration should also be given to the appropriateness of this from a timing perspective holding in mind the traumatic impact incidents of this nature have upon children.

**Staffing & Workload**

* 1. Consideration should be given to whether staffing and workload arrangements support the delivery of a high-quality, personalised and responsive service that effectively meets the needs of children.

**Skills & Knowledge**

* 1. Consideration should be given to whether there is any additional knowledge and skills that would be beneficial for the workforce and multi-agency partners. This can then be incorporated into workforce development planning where necessary as part of a comprehensive learning and development offer. This includes but is not limited to:

**Partnership & Services**

* 1. The learning review should consider whether children and their families have access to services to meet their assessed needs as well as the effectiveness of partnership working.

**Strengths & Protection Factors**

* 1. The learning review should consider whether assessments, intervention planning and delivery identify aspirations and strengths which children and their families possess.

**Good Practice**

* 1. An opportunity to acknowledge and share any good or effective practice identified in the case.

**Management Oversight**

* 1. Consideration should be given to whether management oversight supports high-quality delivery and professional development. It includes elements of quality assurance, staff supervision, dealing with developing areas of concern in individual cases and facilitating improvements in practice. It is particularly focused on ensuring that actual or potential victims and children themselves are sufficiently protected from harm.
  2. Effective management oversight takes account of the unique demands of an individual case, and the skills, knowledge and experience of practitioners. A skilled manager, taking a fresh look at a case and exercising professional curiosity, can encourage a practitioner to exercise curiosity and critical thinking, address any misplaced professional optimism and take a balanced and informed view of a case. This promotes defensible decision-making and enables the case manager to feel confident and supported to manage risk and identify appropriate interventions and responses.

1. **Action Plan**
   1. Action Plans arising from learning reviews should seek to focus on the right lessons to be learnt which could then be translated into appropriate action to improve future practice. The review meeting as part of ‘checking back’ should ensure that all relevant agencies are held to account for the completion of identified actions.
2. **Communicating Learning**
   1. As part of the ambition to be a learning organisation that actively fosters a culture of continuous learning and development it is crucial that learning is effectively communicated to prevent similar incidents reoccurring in the future. At a minimum, an ‘Understanding our Learning’ meeting will be convened by the Head of Service with the Youth Justice Service to share the context of the serious incident, recognise areas of good practice which can often go unmissed in these circumstances and learning to be applied for the future meaningfully shared.
3. **Strategic Oversight**
   1. The action plan developed in response to serious incidents will be shared with the Youth Justice Executive Board (YJEB) as part of the service managers’ report.
4. **Publication**
   1. There is not a requirement to publicise learning reviews in response to serious incidents externally. However, these may be reviewed as part of external scrutiny (e.g. peer reviews and inspections) and shared with the Youth Justice Operational Group (YJOG) and Youth Justice Executive Board (YJEB).
5. **Flow Chart**