Norfolk County Council

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PRIVATE AND CONFIDENTIAL
Ms Jacqueline Lake
Senior Coroner for Norfolk
Norfolk Coroner Service
Carrow House
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11 November 2019

Dear Ms Lake

Thank you for your Regulation 28 report of 17 September 2019 and your considered recommendations. This letter provides an overview of the actions we have taken following Tyla's death and responds to the specific points in your report.

Following Tyla's death the Norfolk Safeguarding Children Board (now Norfolk Safeguarding Partnership) commissioned a Serious Case Review to ensure that all learning from the circumstances of Tyla's death has been captured and that all agencies take the necessary steps to put this learning into practice. The decision to undertake a serious case review was agreed at the Serious Case Review Group of 12 February 2018.

Following the appointment of an independent lead reviewer the first scoping meeting took place on 1 May 2018 and the multi -agency panel have provided single-agency chronologies and undertaken interviews with all of the professionals involved with Tyla.

The final draft report, with findings and recommendations will be signed off today, 11 November 2019 at the Safeguarding Practice Review Group. Children's Services have a Service Director and a Senior Officer as members of this group and ensure the governance arrangements are robustly upheld and implemented. Once the final report is published we will ensure that a copy is also sent to your office.

There are five overarching learning themes from the review. They relate to better adolescent care pathways, to embed an environment where the fundamental issues in relation to contextual safeguarding are better understood, for a holistic family approach to be better understood and for courageous conversations to take place throughout and across organisations. In essence a whole system approach to working with children, young people and their families.

Although these are recommendations from this particular review, they are all areas of work that are currently underway and being adopted in our approach to working with children and families.

The majority of the specific points made in your report relate to actions to be taken by our health partners. We have been in liaison with health colleagues on these matters and the various health partnerships will be providing you with their joint response to the recommendations pertinent to them.

The specific recommendations for Children's Services was in relation to attending a learning review in relation to the case. A task and finish group has been established, coordinated by West Norfolk CCG to oversee the learning review with your recommendations in mind. I can confirm that a formal learning event took place on 7 November 2019 whereby all professionals and their managers who worked with Tyla were invited. In addition, a further event will take place in early February 2020. Invites will go out to NCC Social Care, NSFT staff, East of England Ambulance and QEH.

I hope I have been able to assure you that we are taking all recommendations seriously and continue to work collaboratively with our partners to learn the lessons highlighted in this case.

Yours sincerely

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Head of Paid Service