Issue 19 - March 2019

Safeguarding Adults Board
LEICESTERSHIRE & RUTLAND

Safeguarding Children Board
LEICESTERSHIRE & RUTLAND

Safeguarding MATTERS

CONTENTS

Welcome..

to our latest edition of Safeguarding Matters. This edition aims to share the learning from Multi-agency Case Reviews, Audits and Research.

As always please share the information with colleagues by way of:

Supervision (1-1)

Management Meetings

Team/Unit Meetings

Learning Events/Training

News Bulletins/Briefings

A recent review highlighted the lack of appropriate response to physical abuse so staff need to familiarise themselves with:

- Changes in LSCB Procedures to reporting bruising, suspicious marks and injuries to immobile babies

And

- Consider all injury and bruising to children in the context of their environment, parental guidance, boundaries and vulnerability.

Safeguarding Children	Safeguarding Adults
http://llrscb.proceduresonline.com/index.htm	
http://llrscb.proceduresonline.com/chapters/register_updates.html	
	www.llradultsafeguarding.co.uk/
	www.llradultsafeguarding.co.uk/home/register/

Children's Case Reviews

Multi-Agency Reviews into cases where children or young people have died or have been significantly harmed raise a number of important issues for staff and managers to consider:

Understanding the Lived Experience

A recent case review involving a young child has resulted in work around focussing on the voice of the child being heard and listened to.

A need was identified to ensure that practitioners don't fail to recognise the voice of the child (including the verbal and non-verbal voice of the child) and understand the child's lived experiences and long term impact of abuse.

http://lrsb.org.uk/voice-of-the-child-voc

There was also a focus on parenting capacity and the importance of trying to understand why a parent has difficulty parenting. This may necessitate an understanding of what the parent's own lived experience of being parented was, as this can impact greatly on their own abilities to become good parents. In particular, where a parent was previously a looked after child then this should be explored to ensure sufficient support is offered.

Information regarding Adverse Childhood Experiences will feature in the next edition of Safeguarding Matters.

Working with Violence and Aggression

'Do I know how to deal with adults who use the fear of violence or intimidation of professionals to try to distract them from focussing on the needs of the children?'

Staff need to take steps to keep safe when faced with violent and aggressive behaviour of adults (parents, carers) but they also need to reflect how this may affect their practice both with families and multi-agency colleagues:

- Recognising Aggressive behaviours – Is it overt? Is it passive? What do other workers think? Don't underestimate the impact.
- Acknowledging how it makes us feel – Anxious and worried (Fight or Flight), angry
- How might we act? – ' I hope they are not in'; 'Not getting to the point'; Avoiding difficult conversations, shifting responsibility to others
- What may be the outcome?: Fear escalating, underestimating risk to children/vulnerable adult, breakdown in multi-agency working.

What will help?

- It is important that within a work environment there is a culture of openness and staff are encouraged to voice their worries
- Include as a specific agenda item at Supervision
- Multi-Agency meetings should routinely address the issue and discuss strategies to mitigate.

Supervision in all agencies should recognise the potential impact on standards of practice when working with adults with violent and aggressive behaviour.

Lack of Engagement, Avoidance and Resistance

'Do I know how to recognise a lack of engagement and avoidance?
What tools do I have to deal with this?

Research and training materials are available via a web page on the L&R Safeguarding Boards website:

http://lrsb.org.uk/lack-of-engagement-and-disguised

http://lrsb.org.uk/uploads/resistance-professional-questions.pdf

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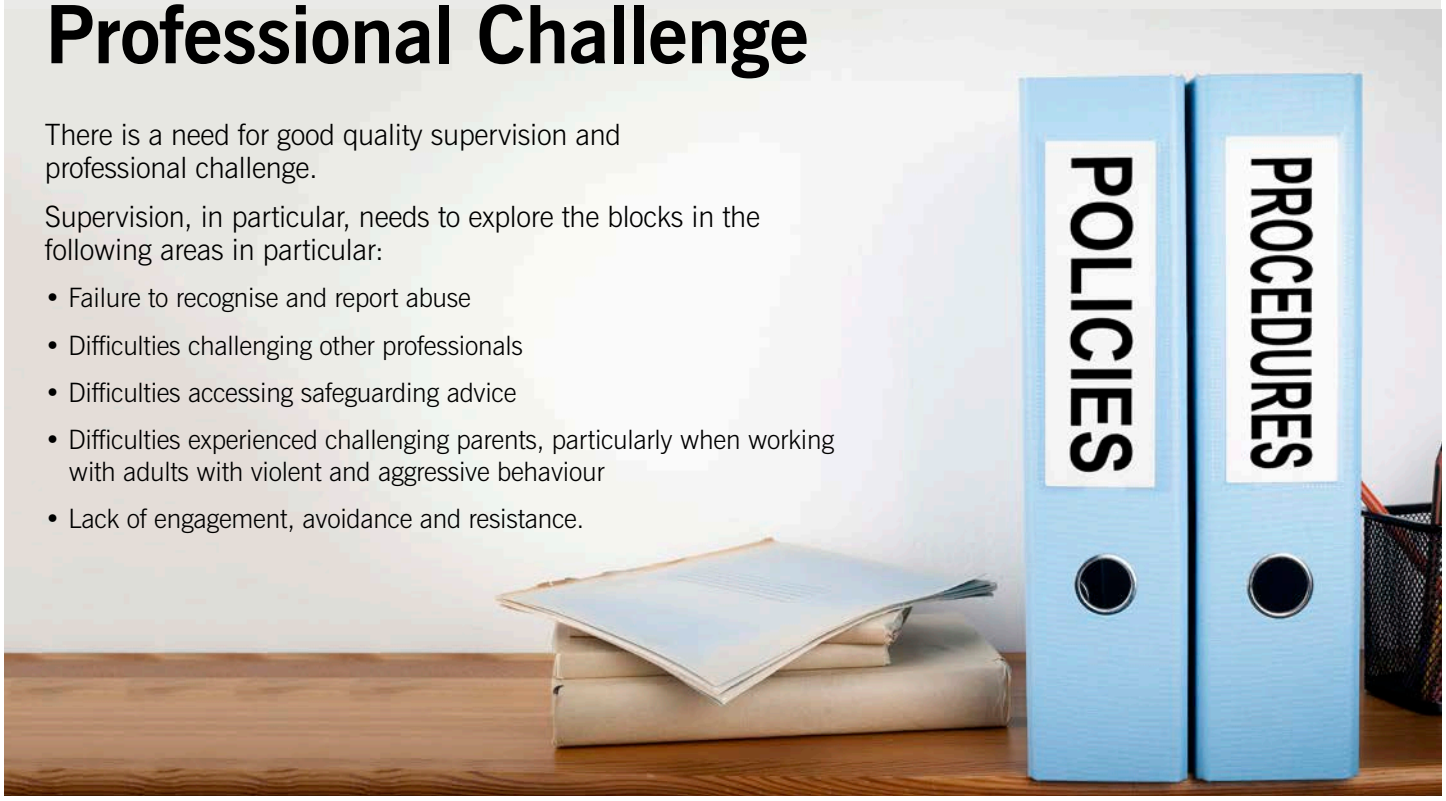
Supervision and Professional Challenge

There is a need for good quality supervision and professional challenge.

Supervision, in particular, needs to explore the blocks in the following areas in particular:

- Failure to recognise and report abuse
- Difficulties challenging other professionals
- Difficulties accessing safeguarding advice
- Difficulties experienced challenging parents, particularly when working with adults with violent and aggressive behaviour
- Lack of engagement, avoidance and resistance.



Adult Case Review

Recognising Co-dependent relationships

In a recent case review, both Adults were identified as having care and support needs and services were offered appropriately; however there was no evidence that the co-dependence of both Adults was recognised within the Care Programme Approach, Assessment and Care Management or Safeguarding Adult processes.

There could have been professional curiosity about, for example:

- Power imbalance (physical, emotional, age)
- Who does 'shopping', 'cleaning'?
- Who sorts out the medication?
- How might one cope without the other?
- Patterns of behaviour throughout the relationship?
- Who relies on who? And for what?
- What do they do together? (What do they enjoy?)

Recognition of co-dependence is particularly important in situations where a number of risk factors coexist – for example, Domestic Abuse, Mental Ill Health and Drug and Alcohol Misuse.

25 Things to Consider for Practitioners and Managers

Please use the updated booklets to prompt discussion in Supervision or other learning forums.

25 Things to Consider (Front Line Practitioners)

Practitioner Responsibilities and Self Assessment Questions		
Recognising Abuse and Harm		
1	Do I have the knowledge and skills to recognise bruising that may be indicative of a non-accidental injury? Particularly pre-mobile baby!	
2	Am I confident that I understand the heightened risk/impact where Domestic Abuse, Mental Health and substance Misuse are present ? (Trilogy of Risk)	
3	Risk/Harm is dynamic- am I alert to changes that may indicate a greater risk? Is familiarity with this case a risk to recognition of significant changes?	
4	Do I have the knowledge and skills to recognise a child/young person's underlying vulnerability to child sexual abuse and exploitation and recognition of early indications of CSE?	
5	Am I up to date with the latest developments in 'on line safety'?	
Procedures		
6	Do I know the referral procedure in the case of a pre-mobile baby with injuries/bruising ?	
7	Is there a clear plan (including contingencies) where a suspected non accidental injury has taken place?	
8	Does my recording reflect the work I have undertaken including the voice of the service user and evidence based decision making? Decisions agreed with manager are recorded	
Direct Practice		
9	Am I sufficiently aware of any history that may impact on parenting e.g. a Looked after Child, Head injury, Mental Ill Health	
10	Am I confident to ask challenging questions about very sensitive matters? E.g. Domestic Abuse, Sexual Exploitation	
11	Do I know how to recognise evasion and lack of engagement ? What tools do I have to deal with this?	
12	Do I know how to deal with adults who use the fear of violence or intimidation of professionals to try to distract them from focussing on the needs of the children'	
13	Have I a clear picture of the lived experience the children or vulnerable adult in this family? Walk in their shoes' through their day	
14	Is there a Young Carer in the family?	
15	Are the needs, views and wishes of the children/vulnerable adult at the forefront, or is the parents/carers agenda dominating? Who is doing all the talking?	
16	Where the child/parents/vulnerable adult/carers have a learning disability or English as a second language have they understood the risks and safety planning? What have I done to address this? Is information accessible?	

Version 4 February 2019- Learning from Safeguarding Reviews developed by Janette Harrison Designated Nurse, Children and Adult Safeguarding CCG and Helen Pearson Board Officer Leicestershire and Rutland LSCB and SAB

25 Things to Consider (Supervisor/Manager)

Supervisor and Manager Assess your own knowledge and skill base before discussing with practitioners		
Recognising Abuse and Harm		
1	Knowledge and skills to recognise bruising that may be indicative of a non-accidental injury? Particularly pre-mobile baby!	
2	The heightened risk/impact where Domestic Abuse, Mental Health and substance Misuse are present ? (Trilogy of Risk)	
3	Risk/Harm is dynamic-? am I alert to changes that may indicate a greater risk? Is familiarity with this case a risk to recognition of significant changes?	
4	Do you/they have the knowledge and skills to recognise a child/young person's underlying vulnerability to child sexual abuse and exploitation and recognition of early indications of CSE ?	
5	Are you/they up to date with the latest developments in 'on line safety'?	
Procedures		
6	Referral procedure in the case of a pre-mobile baby with injuries/bruising ?	
7	Is there a clear plan (including contingencies) where a suspected non accidental injury has taken place?	
8	Recording reflects the work undertaken including the voice of the service user and evidence based decision making? Are your discussions and decisions recorded?	
Direct Practice		
9	Are you/they aware of any history that may impact on parenting e.g. a Looked after Child, Head injury, Mental Ill Health	
10	Confidence in asking challenging questions about very sensitive matters? E.g. Domestic Abuse, Sexual Exploitation	
11	Recognise evasion and lack of engagement ? What tools do they have to deal with this?	
12	Do I know how to deal with adults who use the fear of violence or intimidation of professionals to try to distract them from focussing on the	
13	Encourage staff to 'walk in the shoes' of the children or vulnerable adult in this family? What would their lived experience look like?	
14	Is there a Young Carer in the family?	
15	Are the needs, views and wishes of the children/vulnerable adult at the forefront, or is the parents/carers agenda dominating? Who is doing all the talking?	
16	Where the child/parents/vulnerable adult/carers have a learning disability or English as a second language have they understood the risks and safety planning? What have I done to address this? Is information accessible	
17	What might assist in seeing the whole picture in a complex situation (Genograms and Ecomaps)	

Version 4 Supervisor February 2019- Learning from Safeguarding Reviews developed by Janette Harrison Designated Nurse, Children and Adult Safeguarding CCG and Helen Pearson Board Officer Leicestershire and Rutland LSCB and SAB

E-Safety – Keep up to date!!

In 2018 there was an E-safety survey of year 6 and year 9 pupils across Leicestershire and Rutland. 5,798 surveys were completed by pupils from 34 Secondary schools and 134 primary schools.

- Year 6 pupils said that almost 70% had their own social network profile such as Snapchat or Instagram. 12% had 10 or more online friends they had never met. The most popular sites were Snapchat, Instagram and Pinterest. About 65% used a phone camera or webcam and over 15% said they used it for livestreaming. Of those, over 25% broadcast to everybody online. About 15% said they were online 6+ hours a day and of those nearly 90% said they were or may be addicted to their device. About 95% had learned about internet safety in the last 12 months at school.
- Year 9 pupils – about 60% used a phone camera or webcam online and 15% said they used it for livestreaming mainly using platforms like Musical.ly, Facebook Live, YouTube. Live and Live/ly. Over 10% had sent a naked picture. Over 25% had been asked to send a naked picture; over 30% had unwanted stranger contact; nearly 40% had been threatened, insulted or harassed. Over 20% had agreed to meet up with someone and of those over 50% went alone.

Survey trends present a mixed picture:

- Parents/carers are less likely to keep an eye out
- More children are spending longer online and feeling addicted
- Facebook usage is down and WhatsApp usage is up
- Live streaming is becoming popular: 25% broadcast to everyone
- Fewer young people have 'friends' they don't know and fewer are meeting but are more likely to go on their own
- Fewer are sending indecent images.

UK Safer Internet Centre

UK Safer Internet Centre is a partnership of three leading organisations: Childnet International, Internet Watch Foundation and SWGfL, with one mission – to promote the safe and responsible use of technology for young people.

What we do:

The Centre has three main functions:

Awareness Centre: to provide advice and support to children and young people, parents and carers, schools and the children's workforce and to coordinate Safer Internet Day across UK.

Helpline: to provide support to professionals working with children and young people with online safety issues.

Hotline: an anonymous and safe place to report and remove child sexual abuse imagery and videos, wherever they are found in the world.

www.saferinternet.org.uk/about

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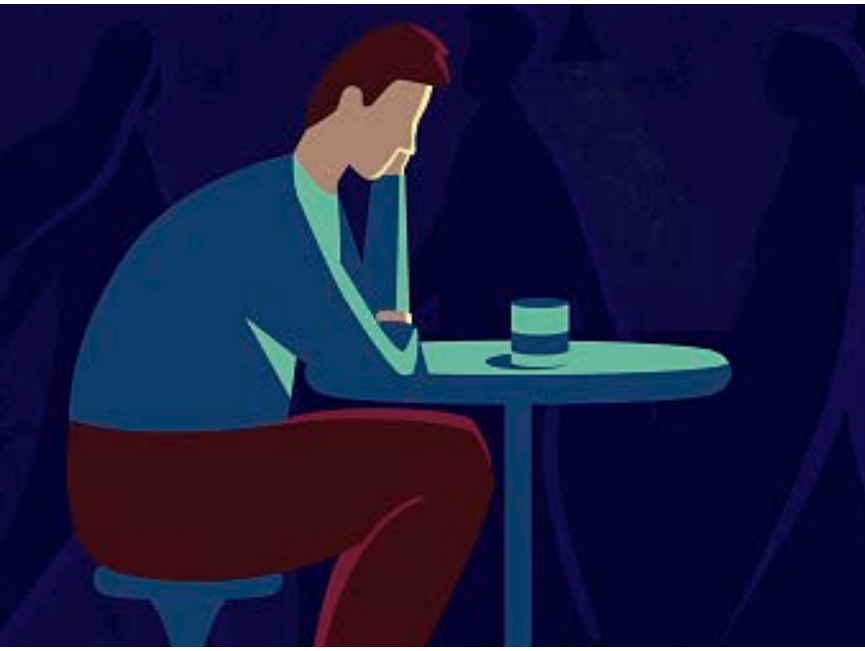
Child Death Review Panel (CDOP)

Suicide Audit report 2009-2017

Rob Howard, Chair of CDOP



These results and recommendations from this piece of work were presented to a number of partners including the Serious Case Review subgroup Members, and the LSCB Development sessions in Leicester City, and the joint LLR Safeguarding Executive. This work is being taken forward in partnership with Leicestershire Partnership NHS Trust (LPT) and Learning Events are being planned for early 2019.

The Child Death Overview Panel (including representatives from Social Care, Health, Police, Public Health and local Children's Hospice) monitors and reviews all child deaths.

Reviewing child deaths includes collecting information about the circumstances of the child's death and family background, with the overall purpose to understand how and why children die, make recommendations to protect other children and to prevent future deaths.

In May 2017, CDOP held a themed panel on suicide, informed by a report compiled by Dr Mike McHugh, Consultant in Public Health at Leicestershire County Council and Departmental lead for Public Mental Health. The report, 'Child Death Overview Suicide Audit report 2009-2017', analysed all the suicides that had been reported to CDOP from April 2009 to April 2017. The report concluded:

Awareness about risk factors within families and across statutory services (including schools) may be helpful to identify high suicide risk patients and preventive measures such as therapies, professional support and education can be introduced.

The risk factors for suicide identified from the evidence and case reviews are very similar and include:

- Mental illness (personal and in the family)
- Family history
- Gender (particularly being male)
- Bullying
- Previous repeated self-harm
- Substance abuse
- Poor social and family support
- Abuse
- Social isolation
- Negative changes in the environment
- Lack of a joined up/family approach (where necessary) in service provision.

Subsequent to the Themed Panel, a further four cases were reviewed by CDOP to identify any urgent action that may be needed to prevent future suicides of children and young people.

After a full discussion and review of each case, the Panel discussed the most prevalent risk factors across the 4 cases. These included:

- Diagnosed or suspected neurological development issues – in particular those leading to rigid or impulsive thinking patterns
- The impact of parental separation on children and young people
- Perceived pressure at schools – it was noted that all of the children had attended private schools – which may have contributed to the perception of pressure to succeed
- All the children had at some point expressed an intension to kill themselves.

Were any of the Suicides preventable?

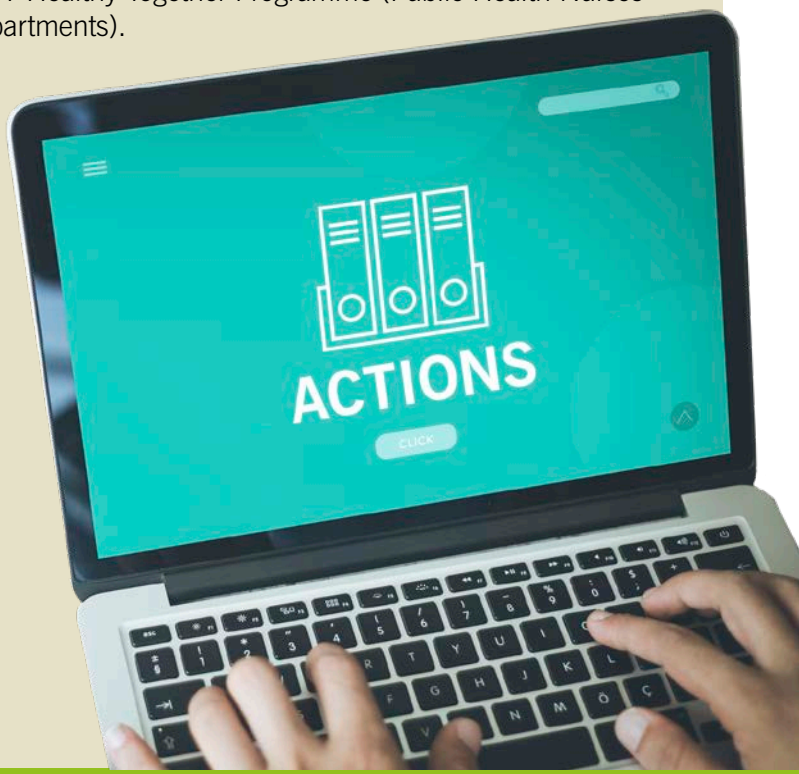
Overall the audit did not find for certain that any of the suicides could have been prevented but it identified a couple of areas for improvement as follows:

- Further education for both adults and adolescents in coping strategies regarding break-ups or bullying – It may be useful to set up support groups (or create stronger links with already existing groups) within schools that pupils can access on an anonymous basis if they are going through stressful situations that they feel they cannot handle.
- Talking about Suicide – There has been evidence to show that discussion about suicide does not encourage/increase the chance of people following through with the act. Being more vocal and discussing the subject between families/schools may be a protective factor as it gives young adults the chance to have an outlet for their stresses that they cannot bring up in a different light.

Conclusion and recommendations

The Panel discussed action that may be taken locally to address the identified risk factors and which may reduce the risk of future suicides:

- Raise awareness with secondary schools (including private and faith schools), further education colleges, and home schooled children to highlight the services that are available to support students, parents and teaching staff. This is a potential action in particular for the LPT Healthy Together Programme (Public Health Nurses commissioned by City and County Public Health Departments).
- Work with front line staff, teaching staff and commissioners to highlight the potential impact on mental health of parental separation – particularly for those children with other risk factors
- Examine the potential to target resilience programmes on children and young people with diagnosed or suspected neurological developmental issues for example Asperger's / Autistic Spectrum disorders and ADHD
- Raise awareness of the potential impact of the pressure to succeed academically on mental health and wellbeing with both students and teaching staff.



It remains a key priority for the work of CDOP for this year.

Child Sexual Abuse Case Audit

Summary of the findings of the July-August 2018 Multi-Agency CSE audit of 5 Cases:

Do more of what works:

- Information sharing between agencies and joint working was good in both Leicestershire and Rutland. Multi-agency risk assessment are now usual practice.
- Hearing and responding to the voice of the children was generally good and well evidenced in Leicestershire cases.
- There were examples of very good persistent work to engage with children and build good relationships by Leicestershire Partnership NHS Trust staff, Social Workers and the Child Sexual Exploitation Team.
- The Police reported improvements in engagement with children on a complex case.
- Good Local Authority transition to adult services was noted in one case in Leicestershire.

Things to improve on:

- In three out of five cases, **Danger Statements and Safety Goals** were either missing or there was no evidence that these had been developed with or communicated effectively with children.
- There were significant gaps in the **quality and recording** of assessments, plans and hearing and responding to the voice of children.
- There were gaps in recorded **supervision** in 4 out of 5 cases.
- **Risk assessments** in 3 out of 5 cases were out of date or not recorded. In addition, **genograms** were missing and plans were not smart in 3 of 5 cases.
- There were areas in a couple of cases where joint working could have been improved, such as multi-agency rather than single agency risk assessment and ensuring CSE was identified as an issue in referrals between agencies.
- In some cases the impact of **children's life experiences** or existing medical conditions on their behaviour was not fully considered.
- In one case a disclosure of potential familial sexual abuse was missed but was immediately followed up.

Clare's Law:
The Domestic Violence Disclosure Scheme (DVDS)

Clare Wood 1973 - 2009

Clare's Law – the Domestic Violence Disclosure Scheme (DVDS) – is designed to provide victims with information that may protect them from an abusive situation before it ends in tragedy. The scheme allows the police to disclose information about a partner's previous history of domestic violence or violent acts.

Does your partner have a violent past? Are you at risk? Clare's Law allows women – and men – to ask these questions of police, who can also use it to offer information to people who have not sought it.

The law was named after 36-year-old Clare Wood, killed by a man with a history of violence.

There is a "right to ask" for partners, or friends and family. The police can use the "right to know" to consider sharing information proactively.

How Clare's Law works

Two routes: Right to ask – where a person (A) or their friend/relative (C) asks for information about a potentially abusive partner (B). Right to know – where police seek to proactively disclose.

Checks are made: Who's who, what is their relationship, what risk of harm exists, what information is there to disclose?

A panel decides whether any risk is sufficient to warrant disclosure, balanced with B's legal right to confidentiality.

Some forces, in urgent cases, allow an appointed officer to make the decision.

B might be told or given the opportunity to object, balanced against the likelihood of this escalating the risk to A.

The information is usually only disclosed to A, even if C made the application.

Strict data protection rules mean it is given face to face and the recipient told he or she could face legal action by sharing it.

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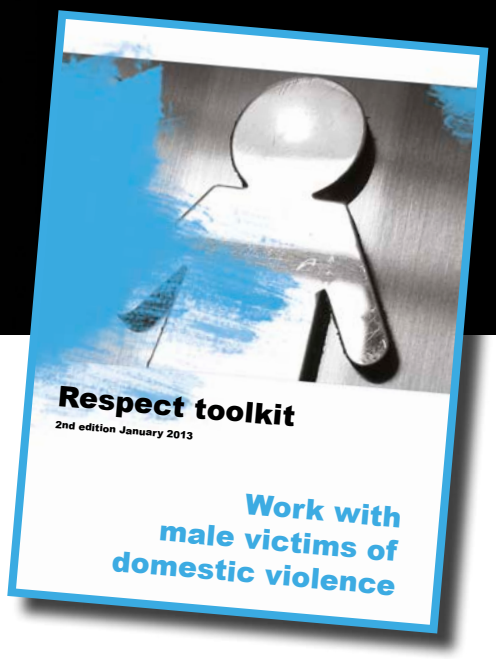
Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE



Respect DV Toolkit – Male Victims

RESPECT is a charitable organisation which works to end domestic violence. More details can be found at: **http://respect.uk.net/**

RESPECT has published the second edition of a toolkit for professionals working with men experiencing domestic violence. The toolkit aims to support and inform work with male victims of domestic violence.

The toolkit can be downloaded, using the following links:

Section 1 - Contents and Introduction

Toolkit for Work with male victims of DV 2nd ed 1. TITLE PAGE, INTRODUCTION

Section 2 - Men and Domestic Violence

Toolkit for Work with male victims of DV 2nd ed 2. MEN AND DV. Respect©

Section 3 - Identifying

Toolkit for Work with male victims of DV 2nd ed 3. IDENTIFYING. Respect©

Section 4 - Assessing

Toolkit for Work with male victims of DV 2nd ed 4. ASSESSING. Respect©

Section 5 - Responding

Toolkit for Work with male victims of DV 2nd ed 5. RESPONDING. Respect©

Section 6 - Case Studies in more detail

Toolkit for Work with male victims of DV 2nd ed 6. CASE STUDIES. Respect©

Section 7 - Research

Section 8 - Bibliography and Further Reading

Toolkit for Work with male victims of DV 2nd ed 7. RESEARCH, BIBLIOGRAPHY Respect©

Research in Practice for Adults (RiPfA)

Research in Practice for Adults (RiPfA) is an organisation which brings together academic research, practice expertise and the experiences of people accessing services to support professionals across the sector. Whilst many of their services require a licence to utilise, they also offer a selection of 'open access resources' which can be used and viewed by anyone. The open access resources can be accessed via the following link:

www.ripfa.org.uk/resources/open-access-learning-resources/

Available Content

Dementia Open Access

https://dementia.ripfa.org.uk/

Site Content:

- Three case studies to help practitioners to think through different situations that people with dementia face.
- Resources to act as a foundation for practitioner knowledge. These include information about:
  - What dementia is
  - Law and policy
  - Useful links.
- Practice guidance to support practitioners to work well with people with dementia, based on 5 essential principles.
- A tools section for quick access to the tools included in the Practice Guidance section.
- Professional Development resources, including top tips for social work practice.

Videos:

- Chief Social Worker for Adults, Lyn Romeo, introducing the website materials (1 minute)
- Webinar 'Supporting confident social work practice with people living with dementia' (58 minutes) – www.ripfa.org.uk/resources/video-resources/supporting-confident-social-work-practice-with-people-living-with-dementia

Carers Open Access

https://carers.ripfa.org.uk/

Site Content:

- Five case studies, each case containing a written and audio overview, sample chronology, assessment and support plan, along with tools and training materials to put learning into practice.
- Resources, featuring an evidence review of social work practice, information on relevant policy and law and social work top tips.
- A library of tools to support different areas of practice.

Videos:

- Introductory video featuring the voices of carers (10 minutes)
- Webinar 'supporting good social work practice with carers' (45 minutes) www.ripfa.org.uk/resources/video-resources/supporting-good-social-work-practice-with-carers-open-access

Older People Open Access

https://gsw.ripfa.org.uk/

Site Content:

- Case study looking at seven time periods with the following provided for each time period:
  - Background biographical information
  - Law and policy
  - Knowledge, evidence and good practice
  - Skills
  - Values and ethics
  - Additional resources
  - Activities

  Tools, such as:
  - templates
  - action planning tools
  - continuous professional development recording sheets
  - critical reflection tools.

Videos:

- Webinar 'Working with Complexity: supporting social work with older people' (56 minutes)
- Webinar 'Just one person': genuine care coordination for older people' (59 minutes) www.ripfa.org.uk/resources/video-resources/just-one-person-genuine-care-coordination-for-older-people

Outcome Focused Practice Open Access

https://outcomes.ripfa.org.uk/

Site Content:

- An explanation of the Outcomes Triangle and its usage, with some resource links
- Outcomes-focused conversations, aimed at practitioners, broken down into five sections, with some sample audio recordings and tools
- Support for managers, with tools and case studies.

Coercive Control Open Access

https://coercivecontrol.ripfa.org.uk/

Site Content:

- Five case studies with learning activities which can be adapted for use in staff development
- Tools for professional development
- Tools for supporting effective, reflective practice
- Background reading and information.

Videos:

- Introduction to the site materials from Lyn Romeo, Chief Social Worker for Adults (6 minutes)
- Introduction to Coercive Control from Polly Neate, CEO of Women's Aid (43 minutes)
- Three short video case studies
- Coercive Control video from Professor Evan Stark (4 minutes)
- 'Don't Put up With It' video (15 minutes)

Safeguarding Adults Conference, November 20th 2018:

Speakers/Resources/Links

Multi-Agency Participants heard a series of presentations from staff across the partnership and engaged in case studies and table top discussions.

Stop Adult Abuse:

Cheshire East Service Users' spoken words': The Service User Sub-group of the Cheshire East Safeguarding Adults Board created this video, which focuses on their own life experiences and sends a powerful message to Stop Adult Abuse: **www.stopadultabuse.org.uk/home.aspx**

Thresholds Guidance can be accessed here through the Multi-Agency Policy and Procedures (MAPP) resource: **www.llradultsafeguarding.co.uk/thresholds/**

Trilogy of Risk:

Materials can be found here **http://lrsb.org.uk/trilogy-of-risk** with a direct link to the video on YouTube here **www.youtube.com/watch?v=csYu4-EdNmA.**

Turning Point **wellbeing.turning-point.co.uk/leicestershire/** provided an overview of their substance misuse services.

UAVA's **www.uava.org.uk/** service offer and LPT safeguarding leads were available for delegates to talk to about mental health provision across Leicester, Leicestershire and Rutland.

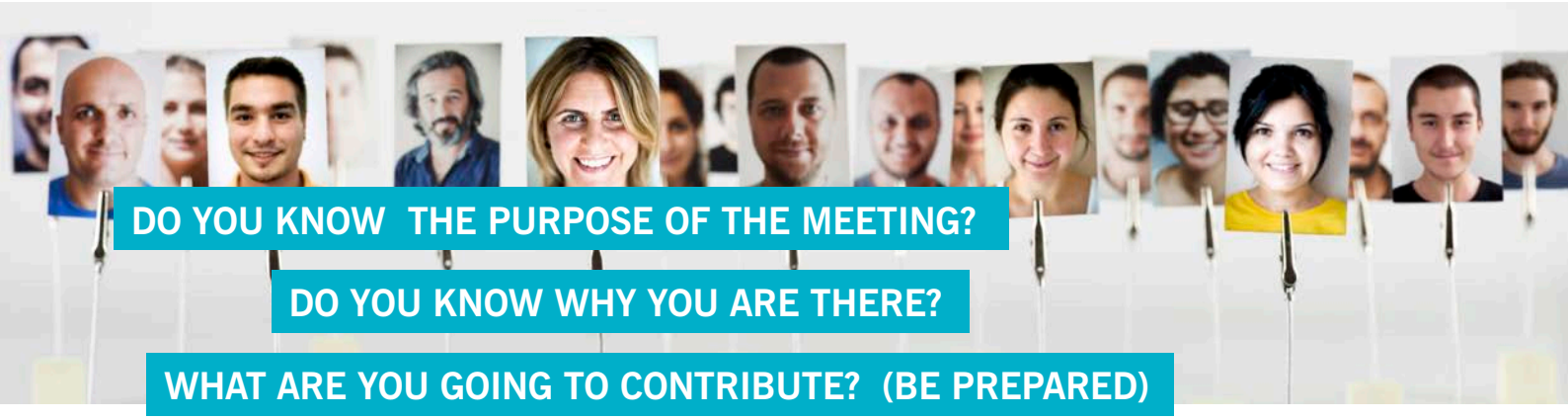
Policy and Procedures

Changes to the Website and update procedures were highlighted: **www.llradultsafeguarding.co.uk/**

Making Safeguarding Personal:

A useful resources can be found here: **www.adass.org.uk/media/5142/making-safeguarding-personal_a-toolkit-for-responses_4th-edition-2015.pdf**, here **www.adass.org.uk/making-safeguarding-personal-publications** and here **www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal/resources.**

Multi-Agency meetings



Children's Initial CP conference:

An initial Child Protection Conference brings together family members (and the child where appropriate), with the supporters, advocates and practitioners most involved with the child and family, to make decisions about the child's future safety, health and development. If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth.

Its purpose is to bring together and analyse, in an inter-agency setting, all relevant information and plan how best to safeguard and promote the welfare of the child. It is the responsibility of the conference to make recommendations on how organisations and agencies work together to safeguard the child in future.

Conference tasks include:

- Appointing a lead statutory body (either local authority children's social care or NSPCC) and a lead social worker, who should be a qualified, experienced social worker and an employee of the lead statutory body
- Identifying membership of the core group of practitioners and family members who will develop and implement the child protection plan
- Establishing timescales for meetings of the core group, production of a child protection plan and for child protection review meetings
- Agreeing an outline child protection plan, with clear actions and timescales, including a clear sense of how much improvement is needed, by when, so that success can be judged clearly.

Core Group:

If a decision is made at a child protection conference that a child is in need of a child protection plan, the core group is responsible for developing that plan and for ensuring that all the recommendations from the conference are carried out.

The core group's task, via the Child Protection Plan, is to:

- Reduce the risks (to the child);
- Prevent the occurrence of further significant harm to the child;
- Safeguard the child's wellbeing – to the point where the child no longer needs a child protection plan.

Child Protection Review Conference:

The purpose of a Child Protection Review Conference is:

- To receive the completed assessment from the Core Group at the first Review (within three months of the Initial Child Protection Conference);
- To review the safety, health and development of the child against planned outcomes set out in the Child Protection Plan and an Assessment;
- To ensure that the measures put in place to safeguard the child continue to be effective and appropriate;
- To consider the child's wishes and feelings;
- To bring together and analyse information about the child's health, development and functioning and the parent's capacity to ensure and promote the child's welfare;
- To consider whether the Child Protection Plan should remain in place or should be changed and set desired outcomes and timescales;
- To examine the current level of risk;
- To determine the need for further assessment;
- To check that inter-agency co-ordination is functioning effectively;
- Make judgements about the likelihood of the child suffering Significant Harm in the future;
- To consider if the child's need for safeguarding can be met without a Child Protection Plan in place.

The Child Protection Review Conference must decide explicitly if the child is at continuing risk of Significant Harm and hence whether there is an ongoing need for a Child Protection Plan. The same decision-making procedure should be used to reach a judgment on this issue as is used at the Initial Child Protection Conference.

If the Child Protection Plan continues, the relevance of the Category of Significant Harm must be reviewed.

Safeguarding Adults

Strategy Discussions And Meetings

In 2018, the Leicester, Leicestershire and Rutland Safeguarding Adults Boards asked for an audit to be completed in relation to strategy discussion and meetings.

Safeguarding leads from multi-agency partners across Leicester, Leicestershire and Rutland identified 3 safeguarding cases each which had been referred as safeguarding concerns within the last 6 months. Where it was identified that the police had been involved in a case, then the details of the case were provided securely to the Police representative, who would then cross check these with Police case records.

It was requested by University Hospitals Leicester that the Local Authorities identify UHL cases as part of the oversight process to ensure these were selected at random and this was also agreed by Leicestershire Partnership Trust.

The audit was completed in a full day meeting. Agencies brought along original case records covering the period from referral to strategy meeting/discussion and the audit was completed collectively by the group using the case records to respond to the audit questions. The audit tool was completed by live input within the meeting. These were the questions:

1. **Did the strategy discussion or meeting take place within 24 hours of the agency receiving the referral?**
2. **Was any immediate risk considered and appropriate action taken?**
3. **Were the appropriate agencies involved in the strategy meeting or discussion?**
4. **Had the views and wishes of the person involved been established? If not, was the plan for establishing this agreed within the strategy meeting or discussion?**

IF IT WORKS KEEP DOING IT

Summary of good practice identified:

- Evidence of swift strategy discussions between ward staff and UHL Safeguarding Team
- Evidence of robust immediate action plan taking account of risks to others within a Leicester City Council organisational safeguarding enquiry
- Rapid response from Police within a Rutland County Council enquiry in attending a bank when concerns were raised about a person who was cashing a cheque where there was concern about pressure from rogue traders
- Evidence of robust enquiry and appropriate challenge by workers in a number of cases.

Recommendations and suggested areas of focus for agencies going forward:

a) Given the delays identified in some cases, it is recommended that, where appropriate, agencies consider their own audits around how immediate risk is managed within safeguarding enquiries within their organisations to assure themselves that robust processes are now in place.

b) Consider the location of multi-agency strategy **meetings** particularly where cases are complex or large scale. It was felt that arranging a strategy **meeting** within the 24hrs stipulated in the policy and Procedures (MAPP) could be problematic, however it was agreed that as long as a strategy **discussion** took place within 24hours to discuss immediate risk then there could be a follow up strategy **meeting** asap.

c) Involving the person or their advocate in the strategy **discussion** or **meeting** was identified as an issue for all agencies. It was agreed that there are a number of reasons why it may not be possible for the person to be involved in the strategy **meeting** or **discussion**, such as due to immediate risks/issues around capacity/ wishes of the person, but this should not become the default position. Where the person had not been involved the reasons for this should be clearly recorded, as well as the plan for involving the person or their advocate at the first opportunity. This should include considerations around mental capacity assessments if there are doubts about the person's capacity to consent to the safeguarding enquiry or advise of their wishes in terms of outcomes.

Contact us

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