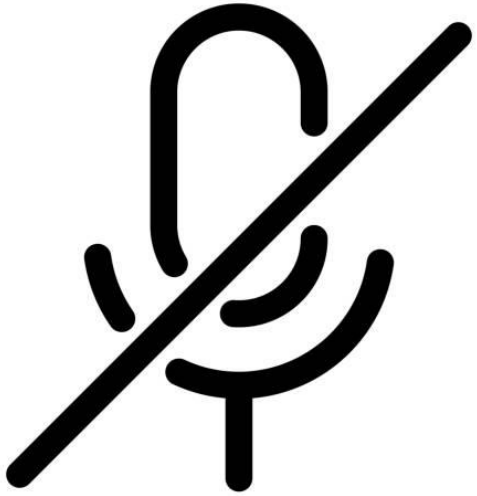
Safeguarding Matters Online Briefing
7th December 2022 9.30-12.00

Welcome to everyone from across the Multi-Agency partnership who support Children, families, adults and carers



Please Mute
Please use the chat for questions which we will follow up after the session
Please give feedback on the Evaluation form (link in the chat)
https://forms.office.com/r/hK0XpqRppV

This Session will cover:

9.30 – Welcome and Introduction to Session - Helen

9.40 -10.00 Safe Sleeping Dr Suzi Armitage

10.00 – 10.10 Learning from Adults Multi-Agency Audits - Escalation and Causing Enquiries to be Made -Helen

10.10 -10.15 FYI LLR SCP SAB – Acronym Exercise Part 1– Helen

10.15 -10.35 – Myth of Invisible Men- Claire Turnbull

10.35.10.45 Break

10.45 -10.55 Children's Procedure update -Threshold Children Thresholds for access to services : Supporting Children and Young People who Self-Harm and/or have Suicidal Thoughts – Liz

10.55 – 11.00 FYI LLR SCP SAB Part 2– Acronym Exercise

11.00- 11.20 Hidden Harm – Alison Taylor Prow

11.20-11.40 Fire Safety, Hoarding and Fire Care – Jav LFRS

11.40-12.00 Acronym Exercise answers and Upcoming Events Helen

12.00 Session Ends

The Role of the Safeguarding Children Partnerships (SCP) and Safeguarding Adult Boards (SAB)

Members from across the statutory, independent and voluntary sector work in partnership to provide strategic leadership to ensure that there are coordinated, effective working arrangements to safeguard children and safeguard adults with needs for care and support across Leicester, Leicestershire and Rutland – We do this through:

- Reviews – Child Safeguarding Practice Review, Safeguarding Adult Review and Domestic Homicide Reviews
- Audits
- Procedures and Guidance
- Training/Tools to support Practice
- Engagement
- Communication's

Leicestershire and Rutland SCP and SAB Leicester City SCP Leicester City SAB

Safeguarding Matters

- Safeguarding Matters is the quarterly newsletter of the Leicestershire & Rutland Safeguarding Children Partnership (SCP), the Leicestershire & Rutland Safeguarding Adults Board (SAB), the Leicester Safeguarding Children Partnership Board (SCPB) and the Leicester SAB.

- The newsletter contains updates regarding the work of the Safeguarding Partnerships and Boards, including developments and resources and learning from Child Safeguarding Practice Reviews (CSPR) and Safeguarding Adults Reviews (SAR)

- From time to time a 'Special Edition will be published

- If you would like to be added to our Safeguarding Matters mailing list and receive alerts when issues are published, please contact LRSPBO@leics.gov.uk

Safer sleeping for babies in Leicester, Leicestershire & Rutland

Dr Suzi Armitage
Consultant Community Paediatrician

Child Death Overview Process
Leicester, Leicestershire & Rutland

‘Whenever an infant dies, it is a tragedy – first and foremost for the infant and family, but also for all those who knew the infant & family, including those professionals who may have worked with them, and for society as a whole’

Kennedy Guidance, 2016

Child Death Overview Process
Leicester, Leicestershire & Rutland

Sudden infant deaths & safer sleeping

Across England & Wales in 2020, 150 babies died & in spite of extensive investigation, their deaths remain unexplained.

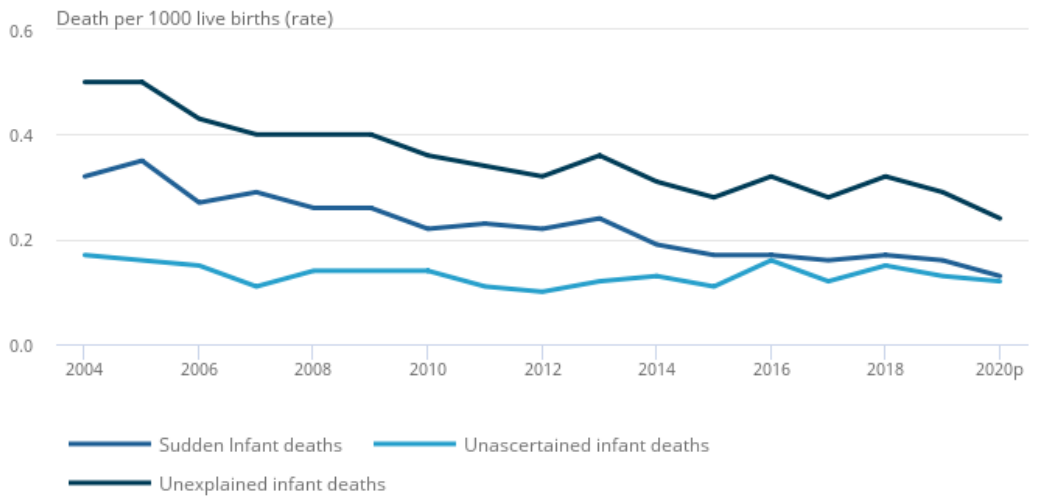
Safer sleep practices can reduce the risk of Sudden Infant Death Syndrome, and reduce the risk of accidental suffocation of infants during sleep.

LLR Child Death Reviews 2016-22:

- Unsafe sleeping was noted as a modifiable factor in 16 infant deaths.
- In 10 of these deaths, co-sleeping with other risk factors (unsafe co-sleeping) was noted.

Figure 1: The unexplained infant mortality rate has generally decreased since reporting began in 2004

All unexplained infant mortality rate, England and Wales, 2004 to 2020p



Source: Office for National Statistics – Deaths in England and Wales

Child Death Overview Process
Leicester, Leicestershire & Rutland

Who is at risk?

Increased risk

Unsafe sleeping positions

Parental smoking

Unsafe sleeping environments

- Unsafe co-sleeping
- Overwrapping
- Soft sleep surfaces

Parental alcohol & drug use

Poor antenatal attendance/late booking

Prematurity or low birth weight (<2.5kg)

Reduced risk

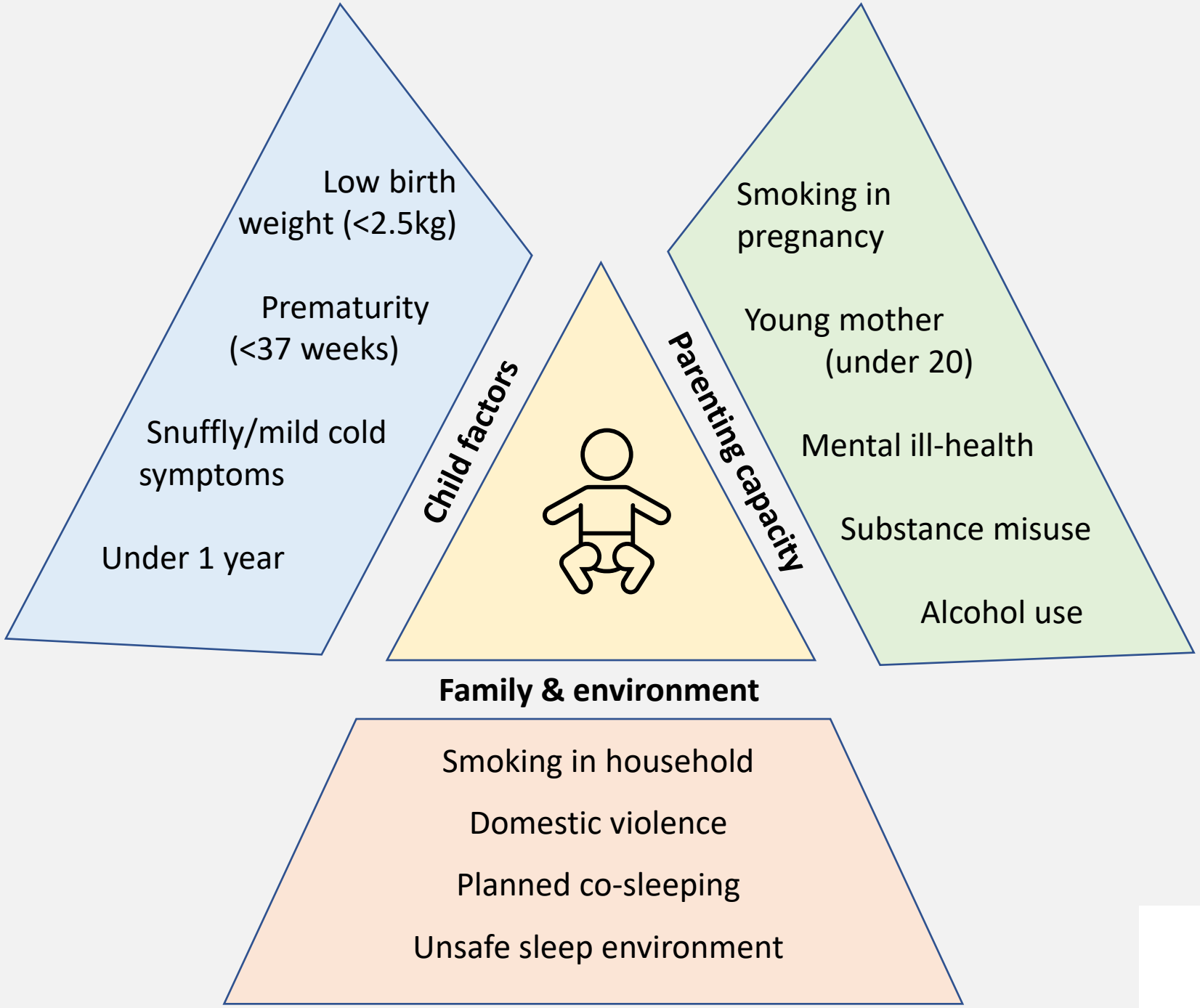
Room sharing with parents/carers for first 6 months

Breastfeeding

Dummy use

Immunisations

Child Death Overview Process
Leicester, Leicestershire & Rutland



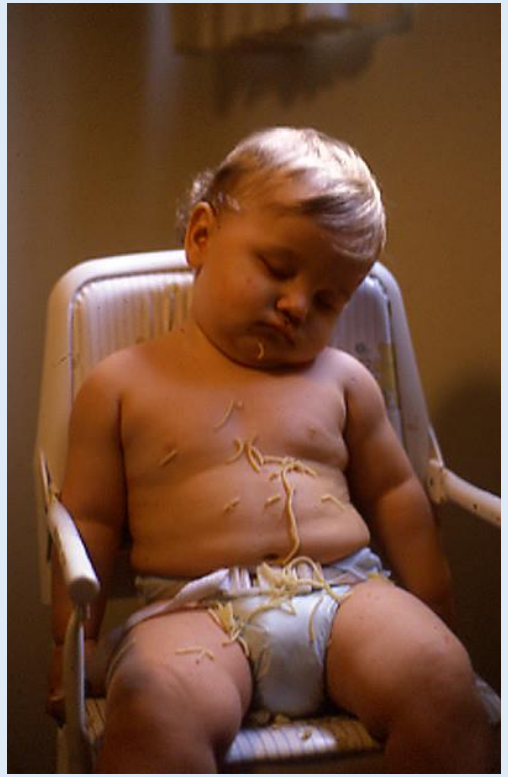
Child Death Overview Process
Leicester, Leicestershire & Rutland

The safest place to sleep….

On their back, feet to foot, in a cot or moses basket, in the same room as a parent/carer for the first 6 months.

However:

- Babies are complex
- Family life is complex
- Parental/carer decision-making is complex



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Reducing the risk: ABC of Safer Sleep

Lullaby Trust ABC:

ALWAYS sleep your baby

on their **BACK**

in a **CLEAR** cot or sleep space.

Child Death Overview Process
Leicester, Leicestershire & Rutland

Reducing the risk: evidence-based guidance

- **Discuss safer practices for bed-sharing:**
  - Make sure baby is on their back on a firm, flat mattress
  - Not sleeping on a sofa or chair with baby (↑risk x 50)
  - Not having pillows or duvets near baby
  - Not having other children or pets in the bed when sharing with a baby
- **Strongly advise parents not to share a bed with their baby if:**
  - Baby was low birth weight (under 2.5kg)
  - Either parent has had 2+ units of alcohol
  - Either parent smokes
  - Either parent has taken medicine that causes drowsiness
  - Either parent has used recreational drugs

Safer Sleeping & the law

- If anyone 16yrs or over:
  - Co-sleeps with a child under the age of 3 years on any surface
  - whilst under the influence of drink/alcohol
  - And causes his/her death by suffocation

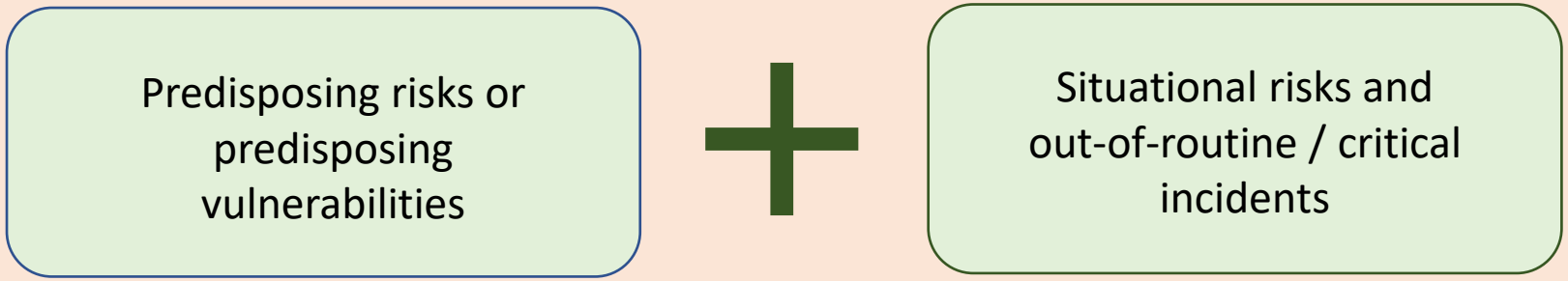
  They could be liable to criminal prosecution (Wilful Neglect) – Section 1. (2) Children & Young Persons Act 1933.
- If anyone of any age:
  - Co-sleeps with a child of any age on any surface
  - whilst under the influence of any drug/substance/alcohol
  - And causes his/her death by suffocation

  They could be liable to criminal prosecution – Section 5. Offences against the Person Act 1861.

Child Death Overview Process
Leicester, Leicestershire & Rutland

Out-of-routine

- Review of SUDI in families where children are considered at risk of significant harm, July 2020.
- Many risk factors for SUDI overlap with those for child abuse and neglect.



- Families typically living in context of recognised background risks
- **Disruptions to their normal routines** meant that they were unable to engage effectively with safer sleeping advice.

Child Death Overview Process
Leicester, Leicestershire & Rutland

Recognising & responding to risks

Prevention

Conversation-based approach - decision-making is complex, explore barriers to following advice

Link between advice and understanding mechanism for prevention

Empower families with knowledge so they can assess their own risks and develop their own plan for safety at every sleep

Protection

Early recognition of & response to factors which mean infants/families are vulnerable

Safer sleeping as part of broader assessment of risk - LLR Neglect Toolkit

Safer sleeping as part of safety planning

Child Death Overview Process
Leicester, Leicestershire & Rutland

Safer sleeping is everyone's business

For every baby:

Curious conversations

Safer sleep for every sleep

Out-of-routine times:

- Family events/night out
- Baby unwell
- Emergency situations

Consistent messaging

Think family

- Partners, grandparents, wider family networks

Embedded in support for broader family risks & vulnerabilities:

- Breastfeeding promotion & support
- Smoking cessation for household members
- Housing
- Alcohol use
- Substance misuse
- Mental health services
- Domestic abuse support

Child Death Overview Process
Leicester, Leicestershire & Rutland

Where to go to find out more

Safer Sleep Advice for families & professionals:

- Lullaby Trust (including easy read info & information in other languages & the full research Evidence Base): https://www.lullabytrust.org.uk

Alcohol consumption & supervision of babies/children:

- Who's in Charge videos developed by Birmingham Safeguarding Children Partnership: https://www.bhamcommunity.nhs.uk/about-us/news/latest-news/whos-in-charge-video-campaign/resources/

Safer sleep for Dads:

- 'Lift the baby' website & videos developed by NHS services in Berkshire: https://www.liftthebaby.org.uk

Bed-sharing guidance for professionals:

- NICE Guidance – Postnatal Care: https://www.nice.org.uk/guidance/ng194/chapter/Recommendations

Supporting families in need with baby equipment:

- Baby Basics: https://www.babybasicsleicester.co.uk

LLR Safeguarding procedures:

- LLR Neglect Toolkit: Neglect (proceduresonline.com)

Child Death Overview Process
Leicester, Leicestershire & Rutland

7-Minute Briefing in conjunction with Safeguarding Children Partnership, Leicester Safeguarding Children Partnership Board, Child Death Overview Process

Acknowledgements:
"Safer Sleep for Babies Fact Sheet 3: Bed Sharing";
"Safer Sleep for Babies: A Guide for Professionals",
The Lullaby Trust
Salford SCP
Warwickshire SCP

1. Background

Child Death Overview Panels continue to report that the majority of sudden unexplained infant deaths occur with known risk factors. Many unexpected baby deaths have modifiable factors, including unsafe sleep practices, and could be avoided. Many risk factors for Sudden Unexpected Deaths in Infants (SUDI) overlap with those for child abuse and neglect.

This 7-Minute Briefing focuses on safer sleep advice for families where safeguarding risk factors exist. For safer sleep advice for all families, the Lullaby Trust provides a lot of useful information.

2. Hazardous Co-Sleeping

The Lullaby Trust notes that many parents will intentionally or accidentally co-sleep with their baby at some point. It is important for them to know that there are some circumstances in which co-sleeping with their baby can be very dangerous, increasing the risk of SIDS & accidental suffocation:

- Either parent/carer smokes (even if they do not smoke in the bedroom)
- Either parent/carer has drunk any alcohol or taken drugs, including any medication that may make them drowsy (when parents are under the influence of drugs/alcohol, a sober adult should be in charge of the baby)
- The baby was born premature (born before 37 weeks)
- The baby was born a low weight (less than 2.5 kg or 5½ lbs.)
- Parents/carers should never sleep on a sofa or armchair with their baby – this can increase the risk of SIDS by 50 times.

3. Key Messages (from The Lullaby Trust)

Babies should always be placed on their back in a clear cot or sleep space for every sleep, day or night. It is safest if they are in the same room as parents/carers for the first six months.

Tell families if they are in a high-risk group and should not bed share – they are much more likely to follow advice if they understand the reasons. If parents are told not to bed share, they may feel they cannot discuss what actually happens and will not therefore get the right advice. Be open and non-judgmental, as families bed share at any given time for a wide variety of reasons. Shock messages that increase fear do not work. Explore why the family is bedsharing and any barriers to following safer sleep advice. Support them to plan ahead to avoid unsafe accidental bedsharing or for when they are out of their usual routine.

4. Role of Practitioners

- Target parents during pregnancy with safe sleep messages. Consider families where parents live apart. Think Family – target grandparents, babysitters and others with caring responsibility for the baby.
- Be mindful of the importance of early recognition of & response to factors which mean infants/families are vulnerable.
- All practitioners should ensure consistent safe sleep messages are conveyed and understood. Do not assume another practitioner has provided information.
- Be mindful of individuals absorbing, responding and acting upon messages according to their learning style.
- Utilise every opportunity to provide safe sleep advice and refer to sources of information.

5. Touchpoints

- Antenatal contact by the Community Midwife at 34 weeks of pregnancy
- Postnatal contact by Hospital Midwife before discharge from hospital
- Discharge from Community Midwifery care 10 days after the birth
- Birth Visit by the Health Visitor/Public Health Nurse at 10 to 14 days post birth
- GP 6-8 week baby and postnatal check

If the baby is subject to a Child in Need Plan or Child Protection Plan, other practitioners will be in touch with the parents / visiting the family home.

6. Raising Awareness and Implementing Learning

- Do we routinely give and discuss information about safer sleep and ask about and view sleeping arrangements?
- Do we routinely consider safer sleeping as part of safety planning and a broader assessment of risk – e.g., via the LLR Neglect Toolkit?
- Do we routinely ask about alcohol, drugs, including tobacco, and medication? Do these conversations take into account use by other members of the family and visitors? Do we consistently reinforce safe sleeping advice where these risk factors exist? Do we provide information on specialist support services?
- Do we always document the advice given?

7. Resources to support practice

Safer Sleep Advice for families and practitioners

Lullaby Trust – including easy read information, information in different languages and the full research evidence base

Safer Sleep for Dads

Lullaby Trust Dad's Zone

"Lift the Baby" website and videos developed by NHS services in Berkshire

Alcohol consumption and supervision of babies

"Who's in Charge" campaign, with videos developed by Birmingham Safeguarding Children Partnership

Guidance for practitioners

NICE Guidance – Postnatal Care

7 minute Briefing Safer Sleeping

Learning from Safeguarding Adult Multi-Agency Audits

Escalation of concerns

The need to understand and follow the Escalation Process

Print Flowchart

Causing Enquiries to be made

Appraise yourself of the guidance

FYI LLR SCP SAB have designed an exercise (they also have responsibility for undertaking CSPR's SAR's and DHR's)

- You have been invited to a MDT meeting to discuss a complex family situation with a number of risk factors – DV, MH, DNA appts (WNB), non engagement, ASB.
- FAMILY
- Jane aged 34 (mother of David) – LD
- Max aged 54 (Jane's partner and Sam's father) – OCD
- Gracie 17 – ADHD and LAC, EHCP,CSE,CCE
- Sam 7 years- SEND,EHCP
- Mary aged 69 – MS
- MEETING ATTENDEES
- SW, PSW, HV,CPN, PC, PO,GP

Myth of Invisible men

Claire Turnbull

Designated Nurse for Safeguarding Children and Adults

ICB LLR

Inclusion

This research is about ‘Invisible Men’

We need to acknowledge that children are still at risk from other people, such as mothers, step mothers and non-birth partners

Myth of Invisible Men – Child Safeguarding Practice Review Panel (the panel) 16th September 2021

Babies under the age of 1 year are subject to more non accidental injury than any other group of children.

Most perpetrators are men, they are the greatest source of risk but we know least about them.

The study comprised fieldwork, a literature review and interviews with perpetrators in prison for harming babies.

The study asked 2 questions:

- How well does the safeguarding system understand the role of the father/male carer?
- How can the system be more effective at engaging and assessing men?

- 92 eligible cases (babies under 1 year injured or killed) out of 257 reported to the panel since 2018. 35% of all the cases.
- At the time of the injury 81% of the babies lived with birth father
- 49% (45) only known to Universal services
- 26% (24) in receipt of Early Help
- 13% (12) CIN
- 12% (11) CPP

Key Facts

Men are more likely to be perpetrators especially where the injury is abusive head trauma (AHT)

Fathers outnumber step fathers but especially in cases where the child is under the age of 1 year

Male children are more likely to be victims of abuse 56% male 44% female

Risk Factors

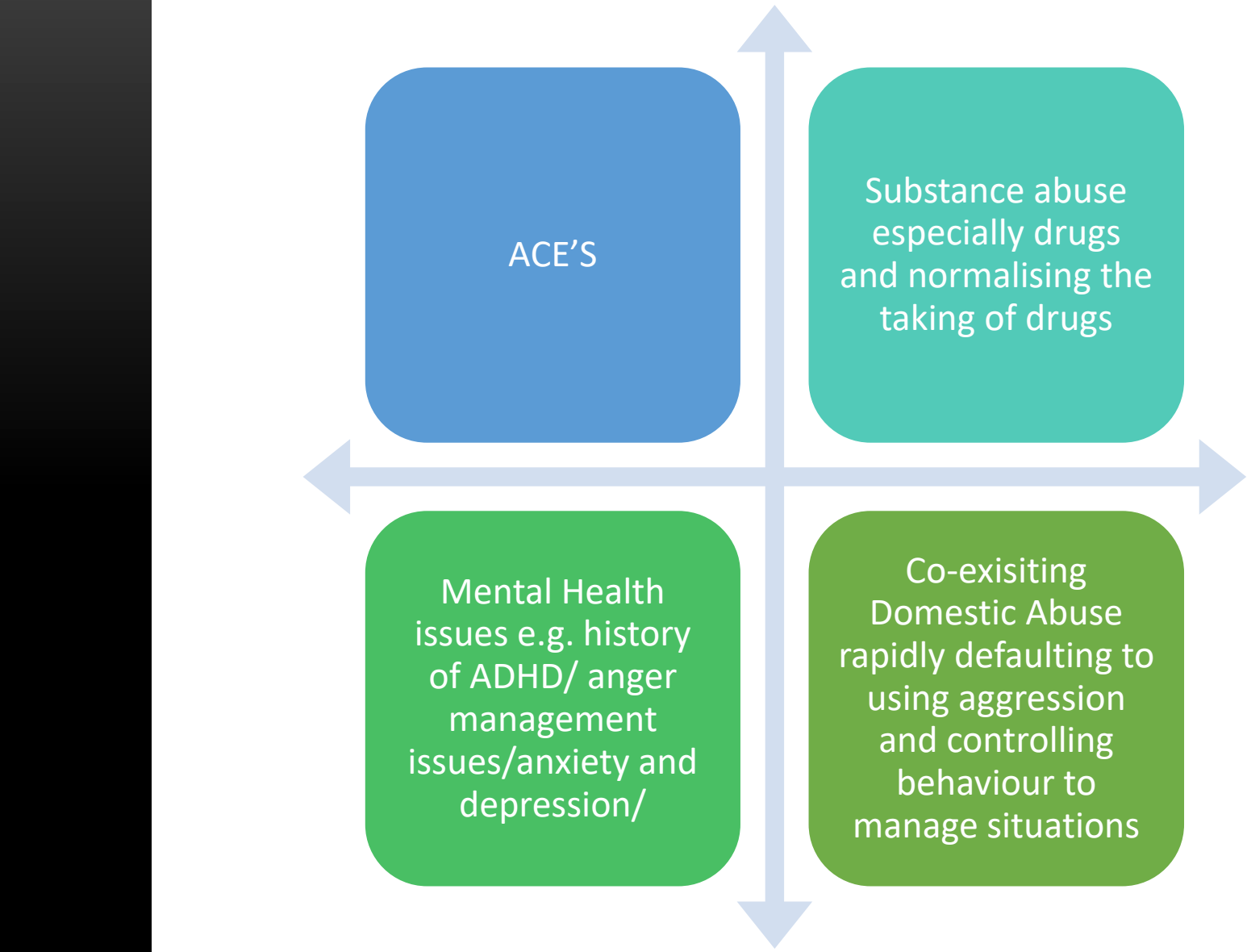
64% (59) Domestic Abuse was present

35% (32) Father had mental health difficulties

33% (30) of the cases the parents were young

5.4% (5) were care leavers

Issues for male perpetrators



Context

- Debt
- Poverty
- Worklessness
- Racism
- Young parent
- Care Leaver
- Violent acts (not necessarily known violent men with a history of violence)

No single indicator

A COMING TOGETHER OF
A RANGE OF CHALLENGES

HISTORY

ILL HEALTH

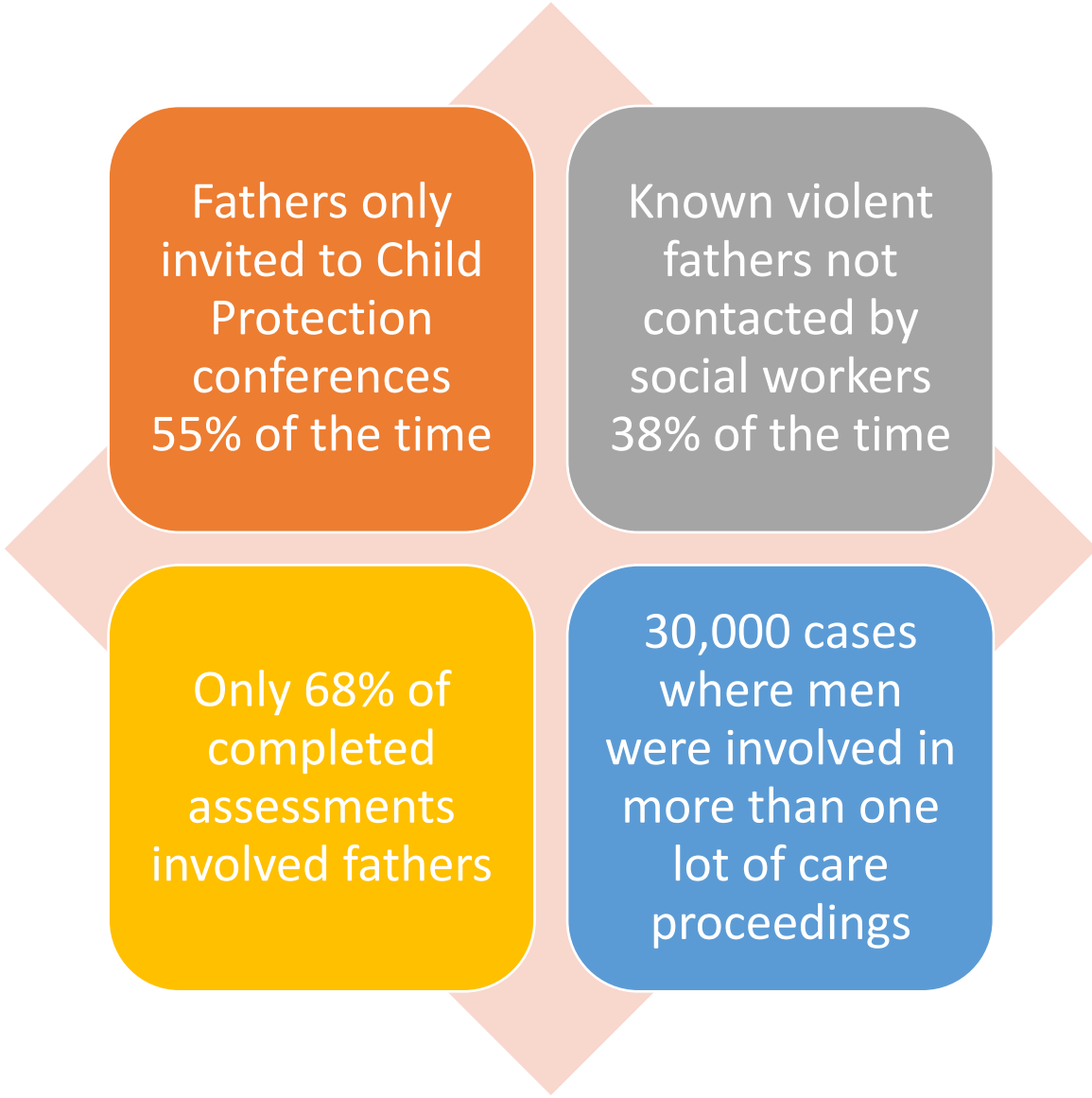
EXTERNAL PRESSURES

Involving men

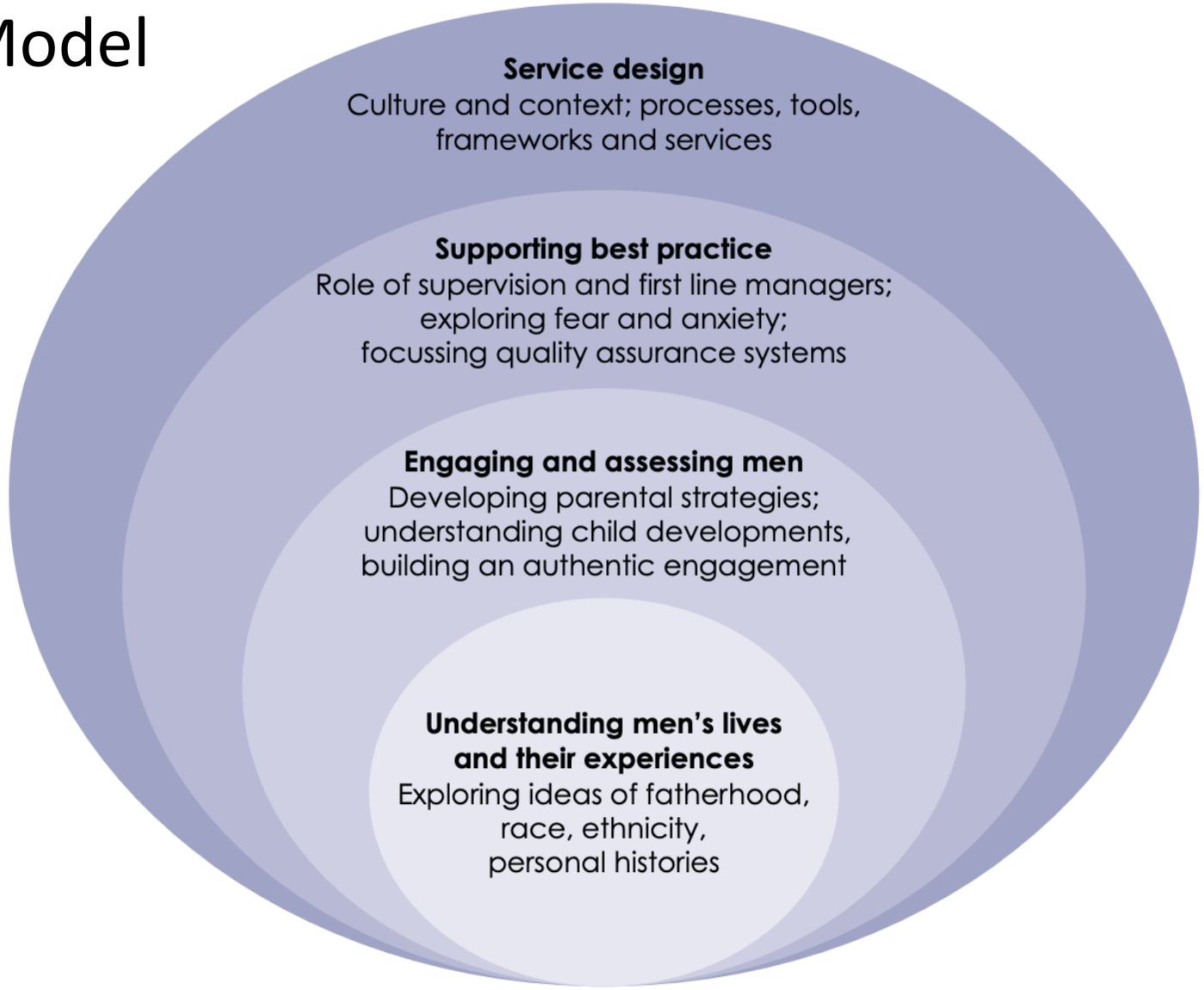
- Men wanted to be involved sharing difficulties about being included
- The men who were less keen to be involved and might present a risk were “enabled” not to be involved

- Men are not specified in key documents e.g. Better Births
- Working with men is not part of health visitor training
- Information where GPs may know risks factors for fathers is not shared with midwives and health visitors (consent issues)
- Inconsistency of Multiagency Front Door responses – what is shared/what is not shared
- Not seeking additional information to get a fuller picture of the family

How men can be excluded



Four-Tier Model



The review recommends that all local safeguarding partnerships develop local strategies and action plans to support improved practice and effective service responses – in three areas:

- Culture and Context
  - HV commissioning and links with other services
  - Leadership expectations about work with men
  - Organisational support for working with violence and aggression
- Processes
  - Link-ups between adults and children's services
  - Response to Domestic Abuse Act
- Tools, Frameworks and Services
  - Workforce Development
  - Supervision and staff management
  - Improved engagement within social care

Conclusions

- Men inflict some terrible and at times fatal injuries on babies - they are responsible for their actions and need to be held to account for them
- Our knowledge and involvement with them is too often too weak and ineffective leading to non involvement and to binary judgements
- Our work with mothers tends to be much more nuanced balanced and sophisticated
- Men who are keen to be involved as fathers express difficulties in being seen and being heard
- They can miss important inputs on how to deal with crying, sleeplessness, support for anxiety about fatherhood ('Silently Panicking’)

Conclusions

- Other men wish to avoid their paternal duties and some of them, because of their circumstances and histories, represent a risk to their babies
- Through fear, intimidation, threats, aggression or absenteeism they will often seek invisibility
- The entirety of the system – from universal provision through to specialist child protection agencies, across both children's and adults and up to and including the Courts - makes it too easy for them to succeed

Men are not, of course, invisible - they are UNSEEN

Engaging Men

Helping men explore and understand fatherhood

Helping men understand child development and the first 1001 critical days

Identify support for men for example Dad Pad, www.iconcope.org, Healthy Together Resources, Chat health, Homestart, Early Help, Centre for Fun and Families, Turning Point,

Assessing Men

Key questions developed for practitioners from the following:

- Recording the names and dates of birth of fathers or male carers in the household or who visit the household or are in a relationship with the birth parent.
- The relationship to the child/children
- The role that the man plays in the life of that child/children
- Experience of caring for children
- Sources of support for the man in the caring role e.g., grandparents, sister, brother friends
- History of the father or male carer – ACE's, Care Leaver? age, domestic abuse, any history of violent acts whether against a person or not,
- Health and well-being – drug and alcohol misuse, physical health problems, mental health – anxiety and depression, ADHD, anger management issues, learning disability or learning difficulty,
- Context – housing, deprivation, employment, financial difficulties, racism,
- Sharing of background information – Adult services, GP information, CSC, Midwifery, health visiting, 3rd sector e.g., Turning Point

Planning for men

- Involving fathers, male carers and none birth parents in services

Planning with men

- Involving fathers, male carers none birth parent in any parenting assessments
- Inviting fathers, male carers and none birth parent to case conferences

Management and supervision

- Supervision of staff by first line managers exploring concerns and anxiety around working with working with men, working with men with a violent history, skills needed to work with men?? Implications for training
- Quality assurance systems

Service design

- Services, processes, tools, and frameworks to work with


YOUR ONLINE
Coffee
BREAK

Children's Procedure Update

Leicester
Safeguarding
Children Partnership Board

WORKING TOGETHER
TO KEEP CHILDREN SAFE

Liz Dunn

Safeguarding Learning Project
Development Officer – SCPs LLR

Safeguarding
Children Partnership
LEICESTERSHIRE & RUTLAND

Child Safeguarding Practice Review

ACTION:

Safeguarding Children Partnership to share:

1. ‘Thresholds for Access to Services for children and families’ (September 2021) and
2. ‘Practice Guidance – supporting children and young people who self-harm and/or have suicidal thoughts’ (2021)

in Safeguarding Matters during 2022/23

Threshold for access to services for children and families in Leicester, Leicestershire & Rutland (Sept 2021)

[Thresholds (Proceduresonline.com)]

Safeguarding Children Partnership
LEICESTERSHIRE & RUTLAND

Leicester
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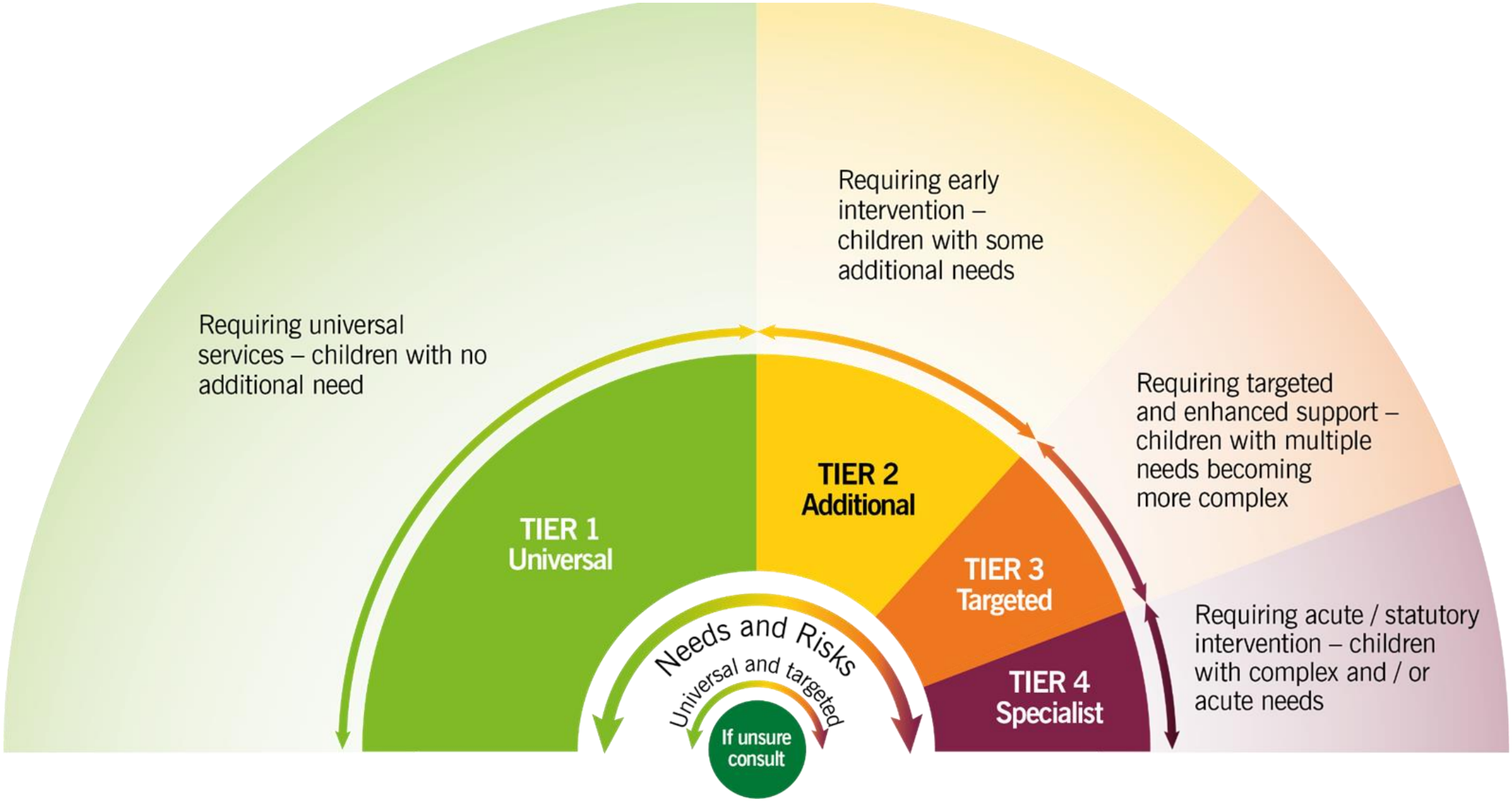
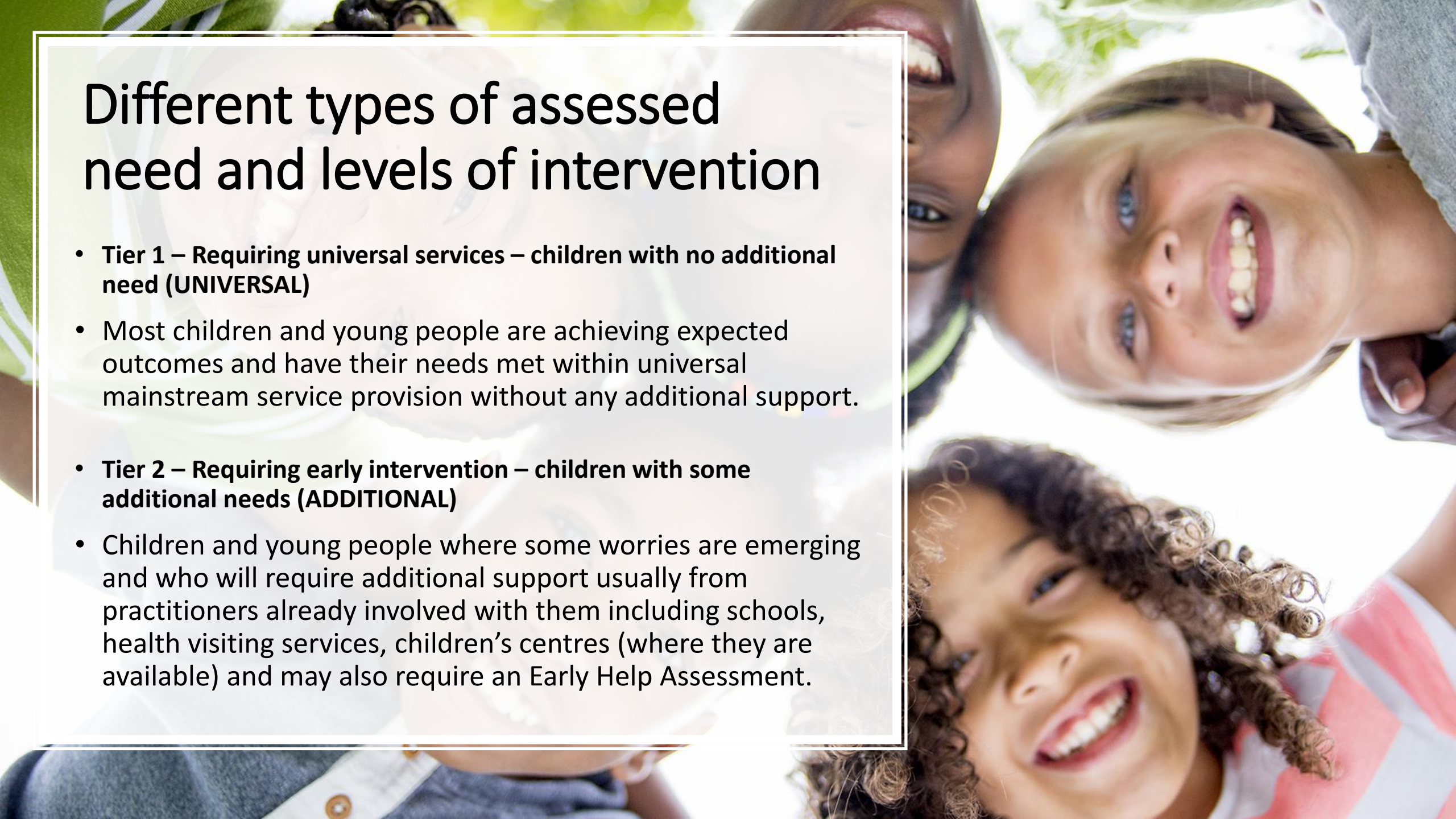
WORKING TOGETHER
TO KEEP CHILDREN SAFE


Requiring universal services – children with no additional need
Requiring early intervention – children with some additional needs
Requiring targeted and enhanced support – children with multiple needs becoming more complex
Requiring acute / statutory intervention – children with complex and / or acute needs
TIER 1 Universal
TIER 2 Additional
TIER 3 Targeted
TIER 4 Specialist
Needs and Risks
Universal and targeted
If unsure consult

Different types of assessed need and levels of intervention

- **Tier 1 – Requiring universal services – children with no additional need (UNIVERSAL)**
- Most children and young people are achieving expected outcomes and have their needs met within universal mainstream service provision without any additional support.

- **Tier 2 – Requiring early intervention – children with some additional needs (ADDITIONAL)**
- Children and young people where some worries are emerging and who will require additional support usually from practitioners already involved with them including schools, health visiting services, children's centres (where they are available) and may also require an Early Help Assessment.



Different types of assessed need and levels of intervention

- **Tier 3 – Requiring targeted early help support – children with multiple needs becoming more complex (TARGETED)**
- Children and young people where there are significant worries over an extended period or where worries recur frequently who would benefit from a coordinated multi-agency team around the family approach, and who will be supported by an Early Help Assessment.
- **Tier 4 – Requiring acute/statutory intervention – children with complex and or acute needs (SPECIALIST)**
- Children and young people who present with acute needs/are very vulnerable and interventions are required to respond to risk of abuse or neglect. They will require a response from specialist service such as Children's Social Care and Community Mental Health Services

services – children with no additional need (UNIVERSAL)	with some additional needs (ADDITIONAL)	children with additional needs becoming more complex (TARGETED)	children with complex and / or acute needs (SPECIALIST)
• Parent/carers can generally provide good care, meeting children's safety, physical and protection needs. • Parent/carers provide a safe and secure environment and support access to consistent and positive activities. • Parent/carers provide secure attachment and consistent caring parenting; guidance and boundaries in	• Parent/carers whose learning difficulties (including literacy difficulties) may impact upon them accessing and engaging with services. • Missing health appointments and/or unscheduled attendance at out of hours services including during pregnancy.	• Inconsistencies in parent/carers accessing support for the following areas: Domestic Abuse, Mental Health or substance misuse, including during pregnancy. • Substance and/or alcohol misuse / learning disabilities or poor mental health affecting the parent/carer's ability to parent safely. • The parenting is having	• High levels of domestic abuse that puts child or unborn baby at risk. • Inadequate care: parent/carers unable to meet child's health / safety / developmental needs, impacting on the child. • During pregnancy inconsistent acceptance of intensive support for mental health, alcohol, and substance misuse issues. • Concealed or denied

Parenting Factors

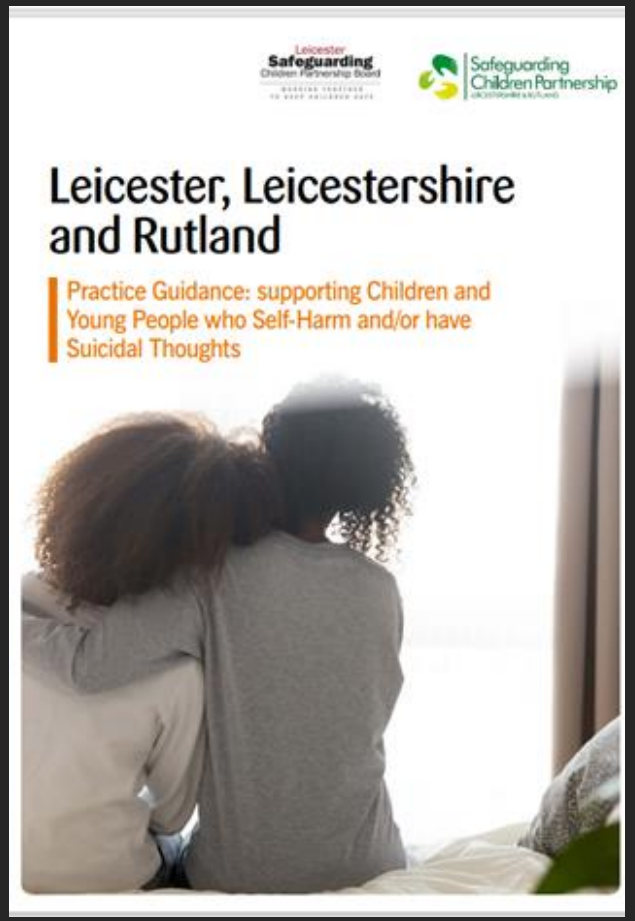
1. Child Factors
2. Parenting Factors
3. Family and Environmental Factors

ACTION	Children and family will access universal services and have no additional need	Gather more information, consider completion of Early Help Assessment with family Involve relevant agencies in the Team Around the Family plan Identify lead professional	Complete an Early Help Assessment with the Family If concerns escalate, seek advice from agency / safeguarding lead Consider completing a MARF	Referral to Tier 3 and 4 services Child requires specialist or statutory involvement Follow Safeguarding Children Partnership Procedures if child at risk of, or suffering, significant harm Refer to Children's Social Care immediately

Types of Services

- available to meet the needs in each Tier

Practice Guidance: supporting Children and Young People who Self-Harm and/or have Suicidal Thoughts (2021)



[LLR Self Harm and Suicide Guidance (proceduresonline.com)]

Leicester Safeguarding Children Partnership Board

WORKING TOGETHER TO KEEP CHILDREN SAFE

Safeguarding Children Partnership LEICESTERSHIRE & RUTLAND

Contents

Principles of our approach

- Building strong relationships with children and young people and their families
- Practitioners understand their role and are curious to find out how they can help children and young people
- Practitioners have confident conversations with children and young people and really listen to what they are telling them
- Working with children, young people, parents and carers builds strong support networks, improves resilience and informs safety plans to reduce risk
- Timely information sharing to get better support for the child/ young person – and understanding consent
- Promoting multi-agency working across agencies to make best use of expertise and skills even when this may be supporting more specialist mental health treatment
- Understanding the impact on staff wellbeing and providing support and training

Contents

Other people involved not present– IMCA, IDVA, CAMHS,SARC

LEGAL FRAMEWORK

S47,S42, MCA, Jane has PR, children have been subject to CiN plan and CPP

ACTIONS TAKEN TO PROTECT

EPO,PPN

ASSESSMENTS

MCA, DASH, MAPPA, discussed at JAG

HEALTH AND TREATMENT

Jane - admitted to ED following OD

Mary – frequent UTI and referrals to ASC via CSC

Max - OCD

“Nigel’s Story”

Learning from a Safeguarding Adult Review

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LLR Integrated Care Board

Aim: to share the learning from a SAR regarding the death of Nigel

Objectives:

- To encourage learning through story-telling.
- To consider how we can work together to promote the rights of adults with a learning disability.
- To generate personal actions from Nigel's story.

* This story talks about the circumstances of the death of a young-man. It could be upsetting so please make sure you access a debrief following this if needed.

Who is Nigel

This recording was made using the information provided by those who knew him well

My BMI was very low-9.

My dad said the nurses were not competent so they stopped coming.

Staff were scared of my parents complaining about them.

I didn't always get the equipment I needed like a bed and a stair-lift

I didn't get the right pressure care and so I got pressure ulcers

Mum didn't like health professionals coming to the house telling her how to care for me.

I got malnourished and I wasn't eating. I felt really weak and sad.

No-one person knew my story

Health could only see me in the Day Centre, when the Day Centre closed health staff couldn't do my pressure wound dressings.

[What the Law says – MASMC (myadultstillmychild.co.uk)]

I became an adult in 1992!

“Parents have a multitude of emotions and conflicting sentiments to contend with when making decisions for their adult children and may not automatically do what is in their child’s best interest despite good intentions.”

[What the Law says – MASMC (myadultstillmychild.co.uk)]

Explain the law to carers & adults so everyone has the same understandings.

- Make sure families understand the MCA & Care Act (2014).
- Include everyone but work within legal frameworks.

What the Law says – MASMC (myadultstillmychild.co.uk)

Ask about my Communication Passport?

- Find out the best way to communicate with the person.
- Involve the person
- Support the person to communicate & give the person the best chance to express their views.

[A Communication Plan for Leicester, Leicestershire and Rutland (betterlives.org.uk)]

Diagnostic overshadowing

"Diagnostic overshadowing happens when a health professional, instead of exploring biological factors, mistakenly makes an assumption that the behaviour of a person with learning disabilities is a characteristic of their disability rather than recognising it as a way of expressing pain or distress. Researchers have highlighted that it is particularly pertinent when new behaviours develop or existing ones increase."

https://www.rcn.org.uk/congress/congress-events/diagnostic-overshadowing

Be aware of your unconscious biases

Unconscious (or implicit) bias is a term that describes the associations we hold, outside our conscious awareness and control. Unconscious bias affects everyone.

https://www.imperial.ac.uk/equality/resources/unconscious-bias/

Lessen the impact of unconscious bias in practice

- Get advice from your Safeguarding Team or manager.
- Use the Safeguarding Thresholds
- Use reflection and supervision to discuss cases.
- Use the escalation process if professional disagreements arise

Learning from the deaths of adults with a learning disability

The voice of the adult was unheard

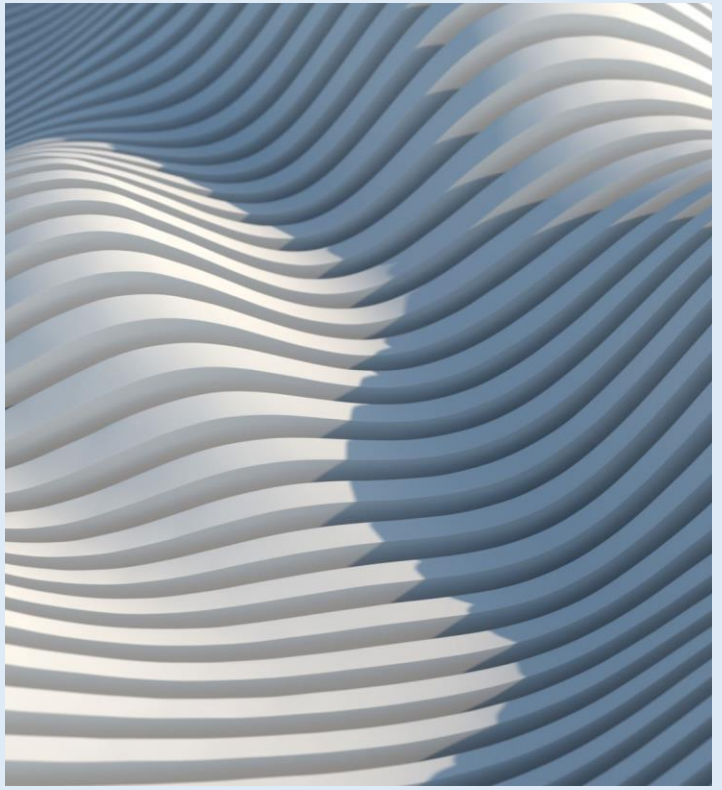
The MCA was not appropriately applied

Diagnostic Overshadowing

Essential care was not provided

Safeguarding concerns were not identified

Opportunities to escalate concerns were not taken



https://www.llradultsafeguarding.co.uk/safeguarding-adults-reviews/?hilite=SAR

Personal Pledges: Making a difference

Human Rights

Further Reading

- https://www.england.nhs.uk/learning-disabilities/improving-health/learning-from-lives-and-deaths/
- https://www.llradultsafeguarding.co.uk/
- https://www.llradultsafeguarding.co.uk/wp-content/uploads/2015/03/Thresholds-Final_December-2019.pdf

SAFER PEOPLE SAFER PLACES

Fire Safety, Hoarding and Fire Care

Javeria Shirazi

LEICESTERSHIRE
FIRE and RESCUE SERVICE

Fire Safety

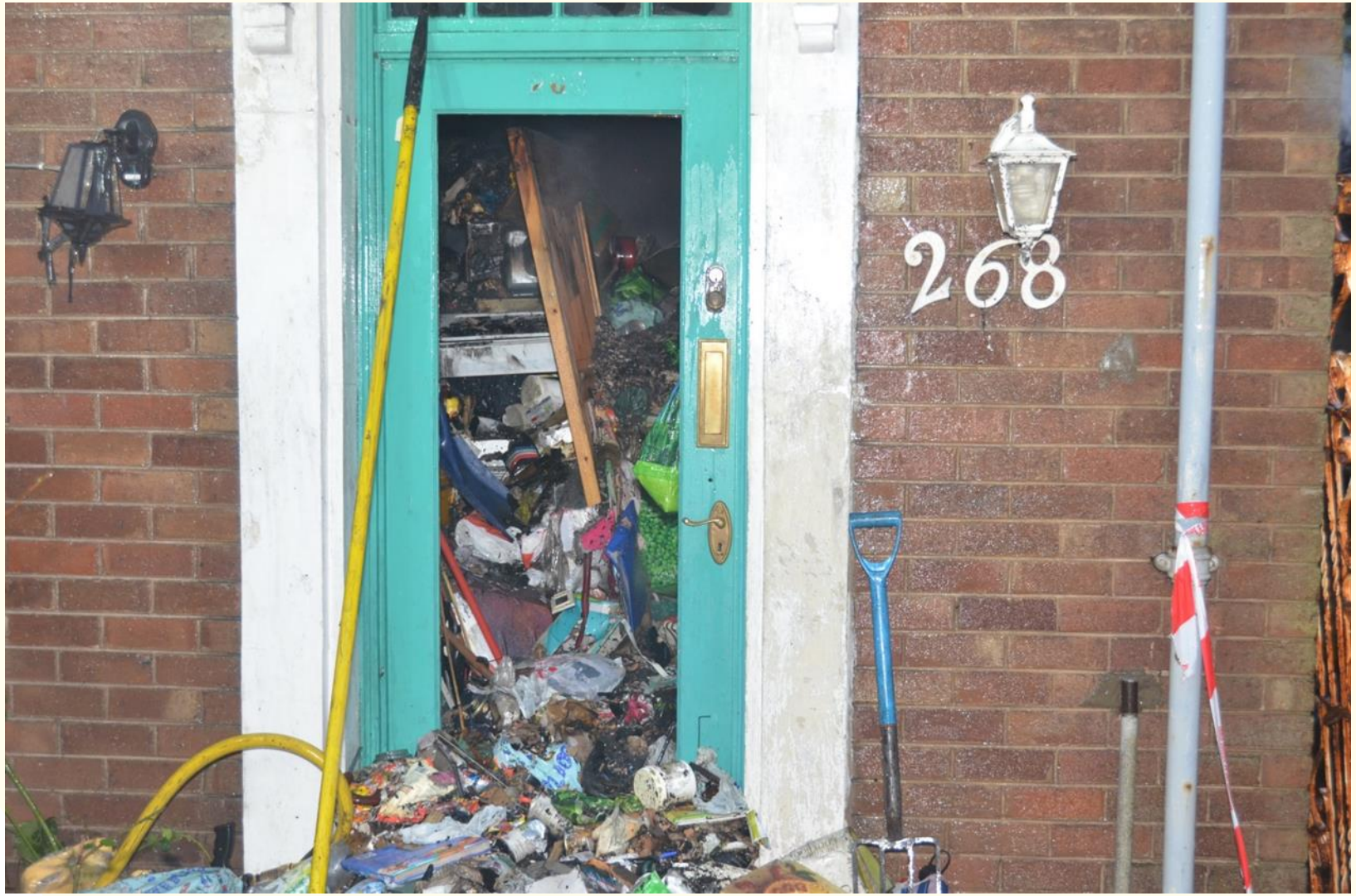
- Minimum- smoke alarm per floor.
- Smoke alarms- protecting exit routes.
- Phone Accessible
- Exit routes- clear
- Keys- available
- Fire Plan
- Closing Doors.

SAFER PEOPLE SAFER PLACES

Arson Threat

- Home safety Check within 24 hours
- Refer into Fire Service via normal referral pathway, follow up with phone call.
- Call 0116 210 5555 out of hours.

SAFER PEOPLE SAFER PLACES



SAFER PEOPLE SAFER PLACES

SAFER PEOPLE SAFER PLACES

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SAFER PEOPLE SAFER PLACES

Red- 7 Plus and above

- Safeguarding Matter
- Referral: ASC/ Fire Service/Housing
- Multi Agency working.

SAFER PEOPLE SAFER PLACES

Current Cases

- Reviewed every 3-6 months.
- Discussion with partner agency.
- Number of Fire Engines.
- VARMS/MDT

SAFER PEOPLE SAFER PLACES

Hoarding Peer Group

- Last Wednesday of the Month
- Venue- City Fire station.
- Specialist Hoarding Social Worker- City
- Safer Spaces- County
- Light refreshments: Tea/Coffee/ Biscuits.

- Please contact Fire Service- Safeguarding Team.

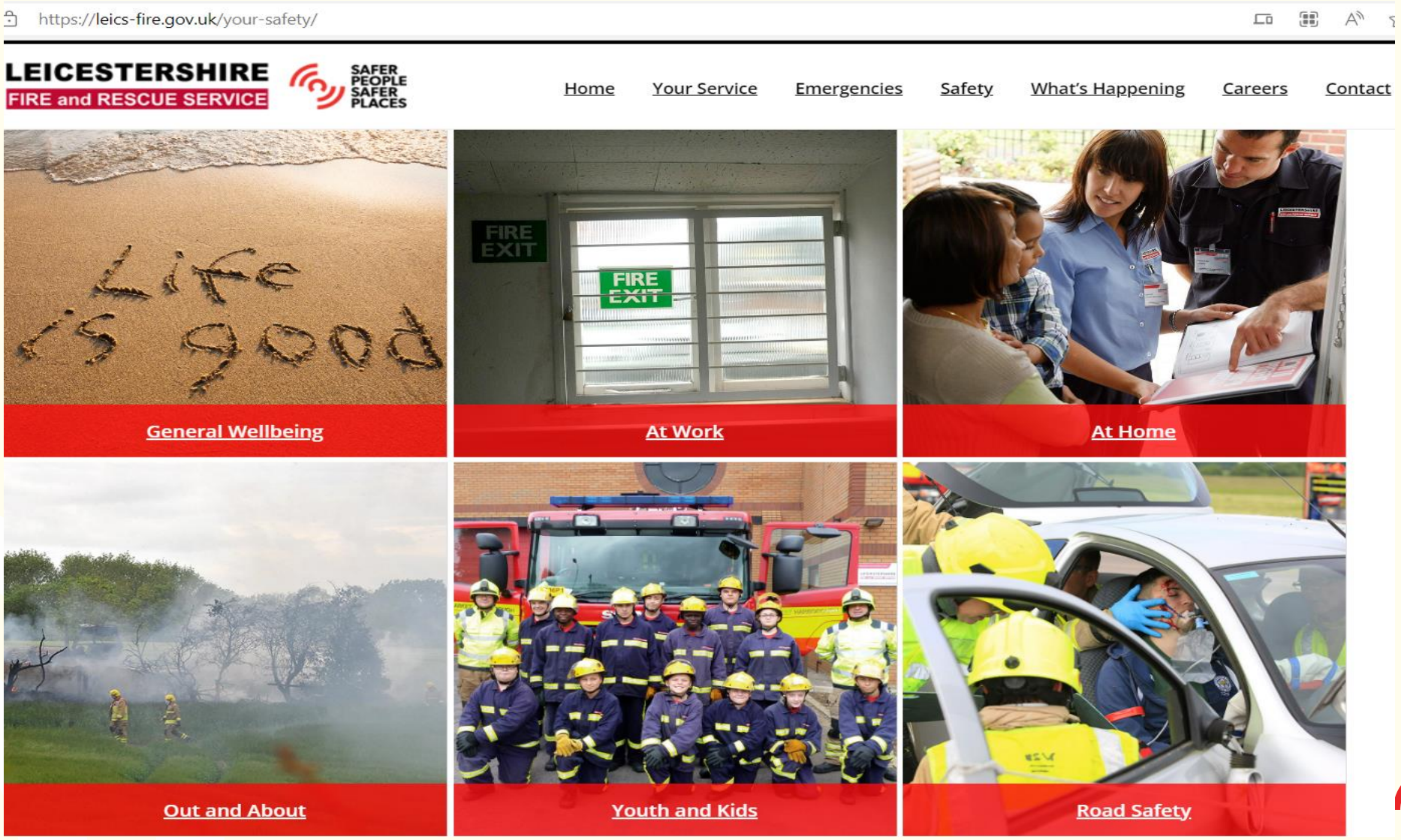
SAFER PEOPLE SAFER PLACES

Fire Care.

- Fire Setters programme
- Free, confidential service- up to 18 years
- Parental consent.
- Numerous sessions with young person.
- Home or at school.
- Home safety Check- risk.

SAFER PEOPLE SAFER PLACES

Safety (leics-fire.gov.uk)



SAFER PEOPLE SAFER PLACES

Contact details:

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SAFER PEOPLE SAFER PLACES

Multi Agency Safeguarding Adult Learning

- Leicestershire Social Care Development Group (LSCDG)

The training plan consists of fully funded courses, such as

Moving & Handling

Autism

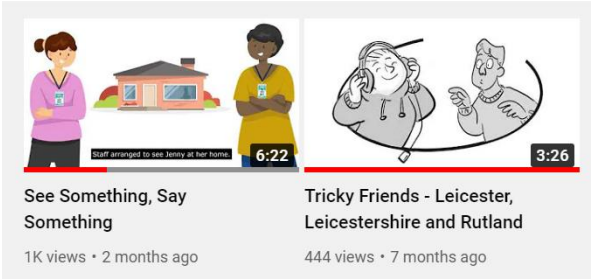
Dementia Education Programme

Safeguarding Adults

Mental Capacity Act

Leadership Modules

- LLR Safeguarding Adults Boards YouTube



Multi Agency Safeguarding Children Training

A Selection of what is available:

- Programme of training delivery 'Hidden Sentence – The Impact of Parental Imprisonment on Prisoner's Children'
- Programme of training being delivered by Barnardo's around Trauma Informed Practice

Both of the above are funded by the Violence Reduction Network

- Core Awareness in Safeguarding Children and Young People – monthly sessions
- Designated Safeguarding Lead training for those outside of the school environment
- Signs of Safety introductory briefing for multiagency partners
- FII – information session on the new Procedure
- Kooth – Information Session on the online service

All accessed through this link:

LLR Safeguarding Children Partnerships Events | Eventbrite

FYI LLR SCP SAB have designed an exercise (they also have responsibility for undertaking CSPR's SAR's and DHR's)

- You have been invited to a MDT meeting to discuss a complex family situation with a number of risk factors – DV, MH, DNA appts (WNB), non engagement, ASB.
- FAMILY
- Jane aged 34 (mother of David) – LD
- Max aged 54 (Jane's partner and Sam's father) – OCD
- Gracie 17 – ADHD and LAC, EHCP,CSE,CCE
- Sam 7 years- SEND,EHCP
- Mary aged 69 – MS
- MEETING ATTENDEES
- SW, PSW, HV,CPN, PC, PO,GP

Other people involved not present– IMCA, IDVA, CAMHS,SARC

LEGAL FRAMEWORK

S47,S42, MCA, Jane has PR, children have been subject to CiN plan and CPP

ACTIONS TAKEN TO PROTECT

EPO,PPN

ASSESSMENTS

MCA, DASH, MAPPA, discussed at JAG

HEALTH AND TREATMENT

Jane - admitted to ED following OD

Mary – frequent UTI and referrals to ASC via CSC

Max - OCD

- FYI –For Your Information
- LLR – Leicester, Leicestershire and Rutland
- SCP –Safeguarding Children Partnership
- SAB – Safeguarding Adult Board
- CSPR –Child Safeguarding Practice Review
- SAR – Safeguarding Adult Review
- DHR – Domestic Homicide Review
- MDT – Multi-Disciplinary Team
- DV – Domestic Violence
- MH – Mental Health
- DNA – Did Not Attend
- WNB – Was not Brought
- ASB –Anti-Social Behaviour
- LD – Learning Disability
- OCD – Obsessive Compulsive Disorder
- ADHD –Attention Deficit Hyperactivity Disorder
- LAC – Looked After Child, Local Area Co-ordinator
- EHCP-Education Health and Care Plan
- CSE- Child Sexual Exploitation
- CCE- Child Criminal Exploitation
- SEND – Special Education Needs
- MS – Multiple Sclerosis
- SW – Social Worker
- PSW- Principal Social Worker

- HV – Health Visitor/Home Visit
- CPN – Community Psychiatric Nurse
- PC –Police Constable
- PO –Probation Office
- GP – General Practitioner
- IMCA = Independent Mental Health Advocate
- IDVA –Independent Domestic Violence
- CAMHS- Child and Adolescent Mental Health Services
- SARC Sexual assault referral centre
- S47 Children Act - Duty to investigate
- S42 Care Act – Duty to Investigate
- MCA – Mental Capacity Act/ Assessment
- PR –Parental Responsibility
- CiN – Child in need
- CPP – Child Protection Plan
- EPO – Emergency Protection Order
- PPN – Public Protection Notice
- DASH- Domestic Abuse Stalking and Harassment
- MAPPA – Multiagency Public Protection
- JAG- Joint Action Group
- ED- Emergency Dep
- OD –Overdose
- UTI –Urinary Tract Infection
- ASC –Adult Social Care
- CSC –Customer Service Centre/Children's Social Care

Thank You
Please fill out our evaluation form

See you again