Safeguarding Adults Board LEICESTERSHIRE & RUTLAND

Safeguarding Children Partnership LEICESTERSHIRE & RUTLAND

Leicester Safeguarding Adults Board
WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

Leicester Safeguarding Children Partnership Board
WORKING TOGETHER TO KEEP CHILDREN SAFE

Safeguarding MATTERS

Issue 24
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CONTENTS

p2 Was Not Heard - News
p3 Coping with Crying babies
Suicide (and self-harm) of Young People
p4 Professional Curiosity
p5 Multi-Agency Planning/ Oversight
p6 Building Confidence in Practice
p7 Safeguarding Children Training

Welcome to the latest edition of Safeguarding Matters

As usual this issue contains articles of interest to staff across the Multi-Agency Partnerships

Your attention is drawn in particular to Learning from Reviews, COVID19 resources and Procedure updates.

CORONAVIRUS

PROTECT YOURSELF & OTHERS

Contact us

Leicestershire and Rutland Safeguarding Children Partnership and Safeguarding Adults Board

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WELCOME

Kay Whyte-Bell Independent Advisor Leicester Leicestershire and Rutland Safeguarding Children Partnerships.

Kay began her social work career in Birmingham, West Midlands, UK, after qualifying in 1986. Since then she has held a range of positions in Local Authorities up to Area Director levels as well as spending time working with Ofsted Inspection and Regional Government positions. Kay has specialised in children's services and in particular safeguarding children before becoming an Independent Social Work and Management Consultant in 2012 and now manages her own Limited Company. In addition, from late 2012, for two and a half years, Kay operated strategically as Chair of a Local Safeguarding Children Board for one London Borough.

Kay has worked extensively with a number of Local Authorities across England since 2011, consulting and training across multi agency partnerships, including Health, Education and Police as significant partners in child protection matters as well with Social Workers, and Managers in using the Signs of Safety. Kay has worked successfully with Senior Leadership Teams, throughout England in their development of wider organisational and practice change using the Signs of Safety principles and processes leading to effectively improved child protection systems that have been formally accredited by UK Government Inspection.

In more recent years, Kay was an integral member of the DfE funded England Innovations Programme led by Prof. Eileen Munro, Dr Andrew Turnell (co-founder of Signs of Safety), and Terry Murphy (ex-Chief Executive, Department for Child Protection, Western Australia) which focused attention on implementation and sustainability outcomes in using the approach with ten Local Authorities.

In addition, Kay has worked internationally, in Western Australia, USA and Sweden, directly working with children and families, supporting local teams and managers, preparing and delivering workshops and presentations, coaching managers, as well as working with partner organisations to develop and deliver many online learning programmes prior to and during the current pandemic.

Annual Reports and Business Plans

The Safeguarding Adult Boards and Safeguarding Children Partnerships have published their 2019-2020 Annual Reports and Business Plans for 2020-2021

Safeguarding Adults

Leicestershire and Rutland

Leicester

Safeguarding Children

Leicestershire and Rutland

Leicester Annual Report

Leicester Business Plan

Funded by MALDG and NHS England

'Was Not Heard' – Great News

The film recently produced by a group of local children and young people was selected to screen as part of the documentary section of the Portobello Film Festival.

The festival was established in 1996 and has become one of the most respected festivals in the country. Whilst the film did not win we are very happy all the hard work of the young people involved in 'Was Not Heard' has been recognised and rewarded by the festival.

Please use the film to generate reflection and discussion with colleagues, the film can be found here

The Voice of the Child/Lived Experience:

Children convey their lived experience not only through what they say but what they do not say and their behaviour.

Practitioners need to think creatively about how they seek the views of children:

Every effort should be made for children to be seen on their own and provide them different ways to get their voice heard

Good Practice Supporting the Voice of the Child

Learning from Case Reviews

Learning has come from several cases in relation to babies, children, young people and adults

Coping with Crying Babies

During this challenging time stress levels at home may be increased

ICON is a programme that provides information about infant crying and how to cope.

Infant crying is normal

Comforting methods can help

It's OK to walk away

Never, ever shake a baby

The ICON website gives useful advice/videos for families and professionals

Suicide (and self-harm) of Young People

The following factors were identified in the lives of young people who have attempted to or have taken their own lives:

- Long term neglect
- Bereavement
- Non-school attendance
- Isolation
- Mental health issues
- Non-engagement with services
- Did not attend appointments – (Was Not Brought)

The following were factors that practitioners /managers need to reflect on and address:

- Voice of the child – ensuring the child's lived experience is heard and understood
- Need for management oversight/supervision ensure practice is what it should be
- Ensure that plans are kept on track and monitored
- Ensure good multi-agency working including clear Information Sharing
- Raise awareness of Private Fostering arrangements

Staff should familiarise themselves with the Self-harm and Suicide Behaviour procedure

Contents ▶

Neglect and Young People

It is not just babies and young children who experience neglect, young people are also affected. The Neglect toolkit is in the process of being updated with information about adolescent neglect and training is planned.

These sessions will be delivered virtually from November onwards. Please look out for dates on these websites: https://lrsb.org.uk/upcoming-events and www.lcitylscb.org/lscpb-learning-development/

Neglect Procedures

Assessments/Safety Planning

Best Practice in getting the whole picture

- Reflect on parental history (including mental health and their own adverse childhood experiences)
- Is mental health, substance misuse, domestic abuse present within the household (not just between partners, could be children, grandparents, lodgers)
- Make sure fathers (present or absent) are included in the assessment
- Ensure all agencies (statutory and voluntary) contribute and share information
- Assessments are not 'static' – things change – risk fluctuates
- Use Professional Curiosity to explore the evidence of what parents are reporting

Professional Curiosity

Waltham Forest Strategic Partnerships have developed a resource pack around professional curiosity which is applicable to both children and family services. They have used material to appeal to a varies different learning styles.

Professional curiosity is a combination of looking, listening, asking direct questions, checking out and reflecting on information received. It means:

- testing out your professional hypothesis and not making assumptions
- triangulating information from different sources to gain a better
- understanding of individuals and family functioning getting an understanding of individuals' and families' past history which in turn, may help you think about what may happen in the future
- obtaining multiple sources of information and not accepting a single setof details you are given at face value
- having an awareness of your own personal bias and how that affects how you see those you are working with being respectively nosey

A lack of professional curiosity can lead to

- missed opportunities to identify less obvious indicators of vulnerability or significant harm
- assumptions made in assessments of needs and risk which are incorrect and lead to poorly focused and incorrect intervention for individuals and families

LOOK

LISTEN

ASK

CHECK OUT

Please see the interactive pdf version which is available here – you can use the menu bar at the bottom as well as click through the papers.

Contents ▶

Multi-Agency Planning/Oversight

A review into a serious assault perpetrated by a young person with complex needs on his brother highlighted the importance of a clear Multi Agency framework for oversight of support, reviewing risk, safety planning, communication and information sharing.

The young person in this case was assessed by Children's Social Care as a Child in Need (Section 17 Children Act) but as they were under CAMHS which is a high tier service, this was accepted as the correct service to lead the support of the child . However, it was recognised that better practice would have been for Children's Social Care to have coordinated Multi-Agency meetings so that when a service is being withdrawn a safety plan is built so that all agencies involved, plus the young person and family know what is happening and have a forum to challenge if needed.

Understanding Terminology to improve communication and practice

Best practice in working together is better achieved through an understanding of the roles each other has, the framework in which work is undertaken and in particular the purpose of meeting together

The use of acronyms can also be confusing

If you should have a query regarding any terminology, please check out the Glossary's in the Safeguarding Procedures

Children

Adults

IF IN DOUBT ASK THE QUESTION

Engagement with People Who Have Needs for Care and Support

Not all adults who go through the safeguarding process are receptive to engaging with services. Complex dilemmas do arise particularly when people appear to rationally or intentionally choose to remain in risky situations including self-neglect.

A new chapter of the Safeguarding Adults Procedures outlines some of the issues and provides guidance and tips on engagement such as:

- identifying, others who may be able to gain access, formal or informal e.g. housing officer, neighbours, shopkeeper, family and friends;
- meeting outside of the home in a place where the adult concerned may feel safe/comfortable e.g. café, housing office, GP surgery, library

THINK CREATIVELY

Procedural Updates and reminders

Procedures are updated for a variety of reasons

- Recommendations from Reviews or Audits to improve working together and outcomes
- Changes in Legislation
- Changes to the structure of how services are provided

We are also taking the opportunity to remind staff to re- familiarise themselves with specific existing procedures

SAFEGUARDING CHILDREN

Concealed Pregnancy

Escalation Procedures

Pre-Birth Procedures

Management of Marks of Concern in Pre-Mobile Babies and Non-Independently Mobile Children procedure

Self-harm and Suicide Behaviour procedure

Neglect Procedures

Private Fostering

Information Sharing

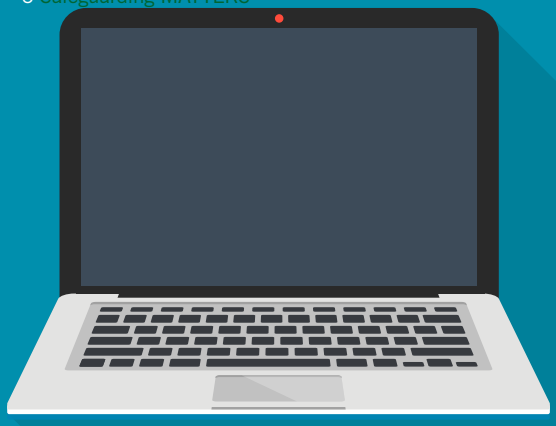
Good Practice Supporting the Voice of the Child

SAFEGUARDING ADULTS

Guidance for Working with Adults at Risk of Exploitation: Cuckooing

Managing Allegations against People in Positions of Trust (PiPoT)

Management / Undertaking a Statutory Safeguarding Adults Enquiry under Section 42 of the Care Act 2014Escalation Procedures



Building Confidence in Practice

RESOURCES

Social Care Institute for Excellence (SCIE)

Home Care Service Providers - Share Best Practice with the Social Care Institute for Excellence (SCIE)

SCIE would welcome hearing from home care service providers with examples of good practice for both working aged and older adults, **specifically around coping with COVID-19 management.**

Please provide any examples by accessing this link

Latest practitioner resources from the Social Care Institute for Excellence (SCIE)

Dignity in Care: www.scie.org.uk/dignity/care

These resources combine videos, stories, case study examples and supporting information to cover the following areas:

- Defining dignity in care
- Recognising the individual
- Skills and strengths
- Information and communication
- Freedom to choose
- Privacy
- Involvement and inclusion
- Warmth and kindness
- A dignified life
- A dignified death

There is also a Dignity in care video library:

www.scie.org.uk/dignity/care/videos available for practitioners to use.

Safeguarding adults training webinar series:

www.scie.org.uk/care-providers/coronavirus-covid-19/virtual-courses/safeguarding-adults-training-webinar-series

with recordings of the training webinars covering:

- What is safeguarding?
- Making safeguarding personal
- Information sharing for safeguarding
- Safeguarding and human rights
- Section 42 enquiries for providers
- Self-neglect and safeguarding

COVID-19 Webinars:

www.scie.org.uk/care-providers/coronavirus-covid-19/webinars including upcoming events and recordings of previous webinars.

Innovation and inspiration: examples of how providers are responding to coronavirus (COVID-19)

For more information, please see the full reports:

COVID-19 insight: issue 4

Innovation and inspiration: examples of how providers are responding to coronavirus (COVID-19)

Staff bought face coverings to suit people's personalities and interests. For example, one person who is very keen on public transport has a mask with buses on it. Another person who loves anything military has been given a camouflage mask.

Eid dinner, organised via Zoom, for a resident in a room decorated so they could feel like they were sitting at the table with their family.

GP services have staggered clinic times, seeing people who are most vulnerable early in the morning, and holding 'one-stop' clinics for people with more complex/co-morbid conditions such as diabetes

Wellbeing initiatives for staff have included providing quiet spaces, called 'wobble rooms', for staff to take time out. There were examples of having tissue viability nurses and dermatology support on hand for staff suffering skin damage due to the use of PPE

Safeguarding Children Training

Adverse Childhood Experiences (ACEs) and Trauma Informed Practice.

The local Violence Reduction Network (VRN) and Safeguarding Children Partnership have teamed up with Warren Larkin Associates(WLA) to develop a new half-day workshop to be delivered from November onwards.

We know that children who are routinely exposed to situations such as domestic violence, mental ill health, alcohol and other substance misuse problems in their homes experience negative impacts which can last well into adulthood. These chronic stress situations are called Adverse Childhood Experiences (ACEs) and are often associated with poorer outcomes for children in educational attainment, employment, involvement in crime including violence, family breakdown, and a range of health and wellbeing outcomes. The impact of ACEs can continue throughout adult life. It is important that anyone working with children and adults who have experienced childhood trauma understand about ACEs, how that can affect children and adults across the life-course and the importance of being trauma-informed and supporting children and families to build resilience so any negative impacts can be mitigated. This has been proven to have a positive impact on engagement and a wide range of outcomes for children, adults and the communities in which we live and work.

The workshop is aimed at practitioners working with children, young people and adults across different sectors as well as supervisors and managers. It aims to provide participants with a foundational knowledge of ACEs and how trauma-informed practice can make an impact on both preventing trauma and reducing its impact.

LEARNING OUTCOMES

By the end of the session you will:

- Understand the potential impact of adverse childhood experiences (ACE) and other potentially traumatising life events on children and young people
- Have a greater understanding of behaviours in relation to Trauma and ACEs
- Have increased knowledge about why it is important to consider ACE and trauma when working with children and young people
- Have some ideas about how this knowledge can assist you in your role to support
- Meet some of your safeguarding competency requirements

These sessions will be delivered virtually from November onwards. Please look out for dates on these websites:
https://lrsb.org.uk/upcoming-events and
www.lcitylscb.org/lscpb-learning-development/

WARREN LARKIN ASSOCIATES

Violence Reduction Network

Sudden Unexpected Death in Infancy (SUDI) in families where children are considered at risk of harm (June 2020).

This is the second national review commissioned by the Child Safeguarding Practice Review Panel - Fourteen cases were reviewed out of the 40 incidents notified to the Panel between June 2018 and August 2019).

The cases chosen represented:

- The range of circumstances in which SUDI occurs
- Different aspects of safeguarding risk
- Infants under 12 months old who had died suddenly and unexpectedly.
- In twelve cases, the child or family had previously been identified as being at high risk of significant harm.

The term sudden unexpected death in infancy (SUDI) is a descriptive term, used at the point of presentation of any infant whose death was not anticipated. This term is used throughout, rather than the narrower term sudden infant death syndrome (SIDS), recognising that SUDI includes both deaths for which an explanation (medical or external) is ultimately found and those that remain unexplained. Many of the risks, particularly situational and circumstantial risks, are similar regardless of the underlying cause.

The review concluded:

A better understanding of parental perspectives by all professionals enables local areas to:

- adopt a more flexible and responsive partnership with parents
- develop supportive yet challenging relationships that facilitate more effective safer sleep conversations
- co-produce appropriate information and support for parents and carers to aid their decision-making about the sleep environment.

There need to be better links between the work in local areas to reduce the risk of SUDI and wider strategies for;

- responding to neglect
- issues related to social and economic deprivation
- domestic violence
- parental mental health concerns
- substance misuse.

This work needs to be embedded in multi-agency working and not just seen as the responsibility of health professionals.

The use of behavioural insights and models of behaviour change should be investigated to explore whether these can support interventions to promote safer sleeping, specifically with this group of families with children at risk of significant harm.

Approaches such as motivational interviewing hold out promise, particularly when combined with other strategies for family support and risk reduction. Such an approach could include the use of marketing and social media to influence behaviour change and could be linked to ongoing national work to provide consistent and evidence-based safer sleep messages as part of good infant care and safety".

The review report is available at:
www.gov.uk/government/publications/safeguarding-children-at-risk-from-sudden-unexpected-infant-death

Safer Sleeping for Babies

The Lullaby Trust have produced a text free animation that includes all the main elements of their safer sleep advice for parents and family members who don't speak English as their first language or have low literacy. They hope this resource will be useful for all families, but particularly for those where leaflets or videos with text are not suitable. Please watch the text free animation here.

The Lullaby Trust have also created animations on the three safer sleep topics on which they receive the most enquiries:

Summer safety - advice on keeping babies safe when the weather is hot

Sleep position - covers what to do when babies start to roll

Bedding - advice on what basics a baby needs for safer sleep and how to choose the right mattress.

If you like further information on these resources please email:
communications@lullabytrust.org.uk