Advanced Child Protection UPDATE Training Handout

This course is commissioned for professionals from all organisations by the South Gloucestershire Children' Partnership.

The children's partnership is the strategic body that ensures children are safeguarded with appropriate policies and procedures and ensures the children's workforce has access to multi agency training to help equip them working together effectively for children and families. Your feedback on today's course will go directly to the partnership to help ensure the training offer is the best it can be.

This package is designed to complement the trainer led facilitation of this training through discussion and activities. It is put together as a learning aid, and to signpost and encourage additional learning and further development.

Please note that safeguarding and child protection policies and practices change and are frequently updated. Some slides used in the session may not be included as the presentation is continually evolving.

It is entirely your choice whether you use this as a digital resource or print. **There is no requirement to bring a copy to the training session unless this would support your learning style and needs.**

There are additional resources available via the HRLearning & Development website/course details. These include documents relating to specific information and links to resources that you may find useful.

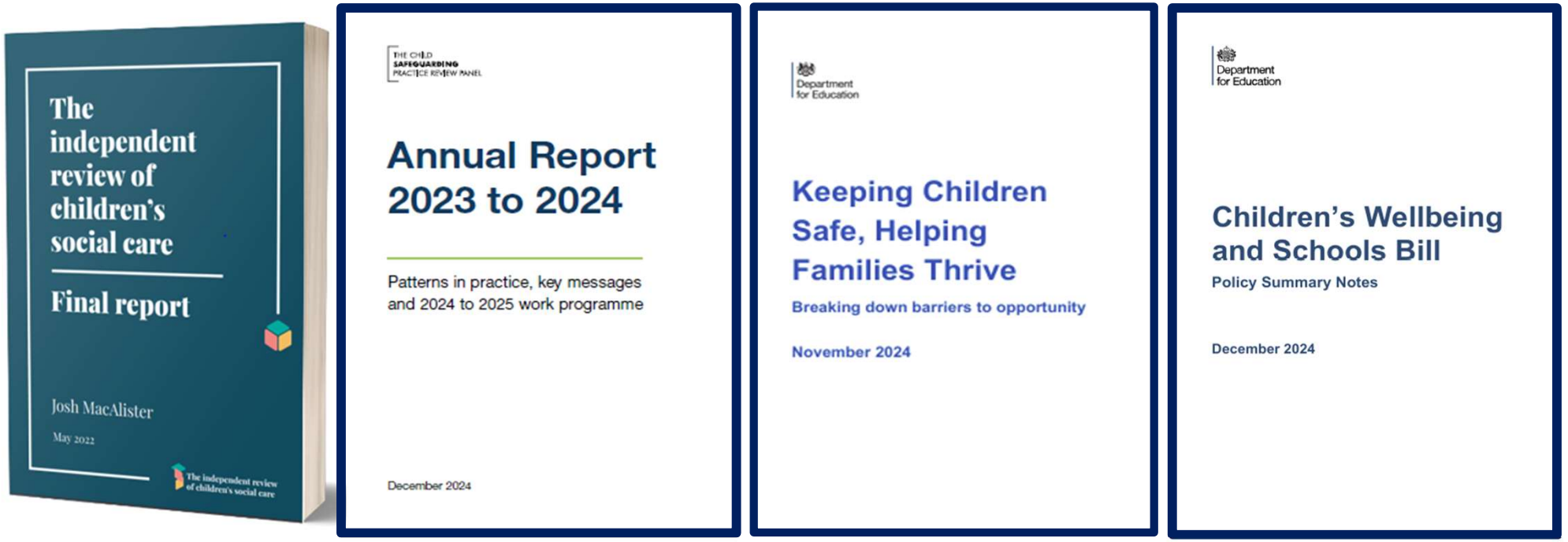
In addition to this training, you will benefit from regular continuous professional development specific to your role. The NSPCC Learning service has amazing resources. Sign up to their CASPAR service to be notified of the latest developments and research. CASPAR | NSPCC Learning (https://learning.nspcc.org.uk/newsletter/caspar)

Please do raise any feedback or resource support needs by email to: HRlearninganddevelopment@southglos.gov.uk

Session Aims

- Reinforce understanding of current legislation, policies, procedures and best practice in safeguarding
- Increase confidence in utilising local tools and resources to support practice
- Encourage and signpost to opportunities to develop knowledge and understanding of emerging safeguarding themes
- Discuss and signpost to learning from local case reviews

Recommendations & Reform



Children's Social Care National Framework, published in 2023, is statutory guidance that sets out the purpose of children's social care as existing to support children and families, to protect children by **intervening decisively** when they are at **risk of harm** and to **provide care for those who need it**, so they **grow up and thrive with safety, stability, and love**

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Children's Social Care National Framework

The four outcomes which children's social care should be aiming for are:

- Children, young people and families stay together and get the help they need
- Children and young people are supported by their family network
- Children and young people are safe outside their homes
- Children in care and care leavers have stable and loving homes

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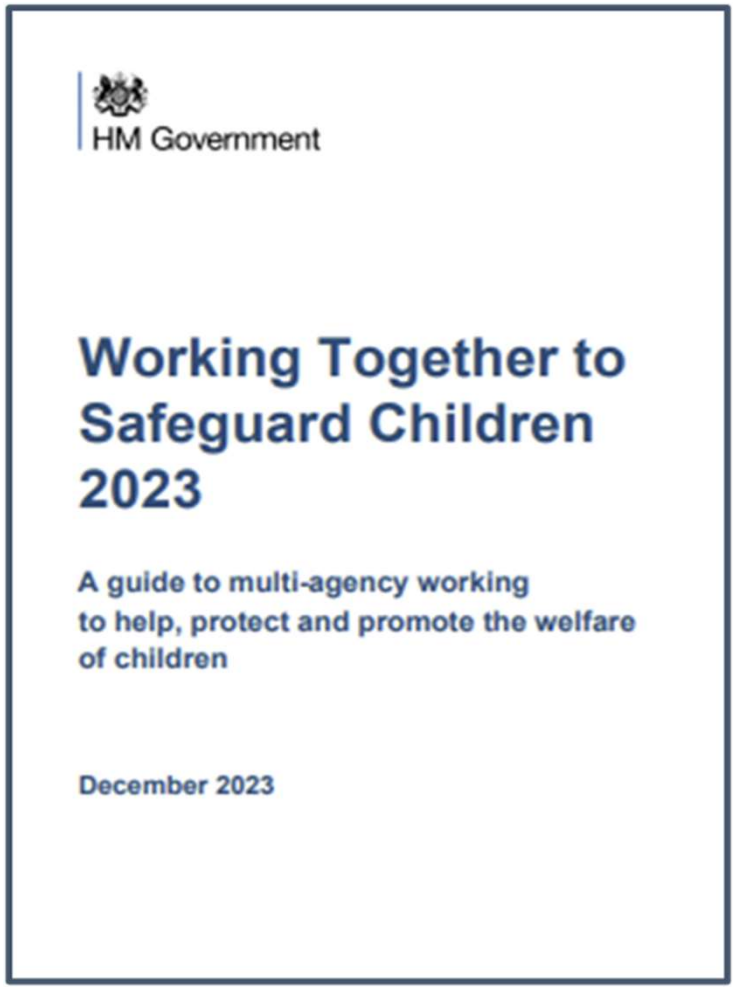
Updated Statutory Guidance 2023



Emphasis on:

- Strong multi-agency relationships…to offer ‘tailored’ support
- Early Help – Risk factors to be considered (Early Help Guide)
- Safeguarding S17 – A wider range of professionals can be the ‘lead professional’
- Children with disabilities – Social Care role clarified
- Considering risks children face outside of the home

South Gloucestershire CHILDREN'S PARTNERSHIP

Child Safeguarding Practice Review Panel Dec 2024

Spotlight Themes

1. Safeguarding children with mental health needs
2. Safeguarding pre-school children with parents with mental health needs
3. Extrafamilial harm

The report highlights how professionals can struggle to find the best and right resources needed to help keep children safe.

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Child Safeguarding Practice Review Panel Dec 2024

The Six key practice themes to make a difference:

1. Critical Thinking & Professional Challenge
2. Whole family approach
3. Racial, ethnic and cultural identity and lived experience impact
4. Vulnerability of babies
5. Domestic abuse and harm to children
6. Risks outside the family

South Gloucestershire CHILDREN'S PARTNERSHIP

Child Safeguarding Practice Review Panel Dec 2024

The Six emerging themes last three reports = : Still relevant

1. Parenting capacity and children with disabilities and health needs
2. Children with complex mental health needs
3. Parental mental health and parenting capacity
4. Children not in school
5. Young carers
6. Working with Gypsy, Roma and Traveller communities

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Multi Agency Quality Assurance Audit: Domestic Abuse Dec 2024

The ten children chosen for this audit were aged between unborn and 7 years old at the time of the audit.

The children have a range of needs and experiences in addition to domestic abuse including parental mental health, parental autism, traveller family, parental substance misuse, parent is a care leaver, neglect

The audit of 10th December 2024 reviewed the records of eight children where there is a Child Protection plan or Child in Need plan under the category of domestic abuse for children under 7 including unborn children. This used the criteria of the current JTAI theme.
The aim of the audit was to ascertain whether there were good multi-agency standards for managing cases and whether organisations have implemented a robust and consistent response in line with statutory and good practice guidance, and the Children's Partnership policies and procedures.

What we are worried about?

- Hard to see and hear information about the children because of the complex adult issues
- Being able to see a holistic picture – tendency to focus on one issue and lose sight of other worries
- 'Start again' pattern following a Marac to Marac transfer.
- Lack of clarity about who the men are in families audited, some assumptions about adults involved being 'dad' when they are not
- Child in Need review meeting notes not visible on social care record – unclear if they have taken place, midwifery and DHI not included
- Limited evidence of co-ordinated approach taken at Child in Need level
- Escalation process not used by any agency
- Lack of use of tools by practitioners
- Voice of child missing but older siblings heard, or children as a collective recorded. Each child needs to be heard.

What Good Practice did we see?

- Think family work undertaken by maternity
- Good information sharing, right support at the right time
- Domestic Abuse screening took place throughout pregnancy
- Clear on records about risk of Domestic Abuse
- Use of traveller network to establish trust
- Perpetrators working with Drive
- Regular contact between social care and probation
- Transition between infant and junior school, with good information sharing
- Voice of father clear in some of these audits
- Joint visit with Health visitor and social worker

Eight cases were audited by the multi agency group and six of these were discussed during the audit meeting

Organisations that audited their involvement with the ten children were: GPs, Social Care, Sirona, NBT, AWP, Next Link, Police, YJS, EDT and Preventative Services, Education.

Themes for Learning: Start again

- Incident led responses rather than holistic review of chronology and history
- Moving in or out of area and transition is a risk time for starting again
- Pattern of non engagement/avoidant behaviour – parent engages initially and then drops away – review history to make sure patterns are identified and not seen as a one off
- Recognition of cumulative risk and impact of harm is needed
- Recurring pattern of repeat child protection plans and PLO process seen in this audit

Domestic Abuse Training – this is for practitioners from all agencies *Click for more*

What is a day in the life of each child like? It is easy to lose sight of this in complex family situations. Each child needs to be heard

Records need to be clear about who is in the room, naming the adults and their relationship to the child

Maintain respectful uncertainty rather than accepting all you are told

Themes for Learning Domestic Abuse alongside other complex issues

What we found: Complex Families

- Parental mental health became focus rather than DA
- Difficult to understand who is the protective parent, who is perpetrator
- Understanding of additional risks due to cultural identity

What needs to Happen?

- Consider use of a multi agency meeting when there are complex family cases
- Ensure all those working with the family are included in multi agency work
- Work alongside the Traveller Liaison Service or other specialist provisions

For escalation click here

Domestic Abuse Tools are available by clicking here

Traveller Liaison service – more information here

Multi Agency Quality Assurance Audit: Young Adults under 25 November 2024

The audit of 13th November 2024 reviewed the records of six adults who were identified through Adult Safeguarding on the theme of transition. All the adults are under 25 years of age.
The aim of the audit was to ascertain whether there were good multi-agency standards for managing cases and whether organisations have implemented a robust and consistent response in line with statutory and good practice guidance, SGSAB policies and procedures and the six key principles underpinning all adult safeguarding work.

The adults reviewed for this multi agency audit are aged between 18 and 25.
3 are female and 3 are male.
3 live in supported accommodation.

The adults in the audit have a range of issues including domestic abuse, drug and alcohol misuse, being a care leaver, mental health, sexual abuse, exploitation, learning disability, Autism, ADHD.

What we are worried about?

The audit group saw concerns in terms of:

- GP not aware of safeguarding for one adult
- Flags not available to show care leaver status
- Information about care and support needs not available to police
- Advocacy not included in any of the cases and all of them could have had an advocate - doesn't appear in records to have been considered
- One adult mainly known to police because of raising concerns for a sibling and in relation to domestic abuse – but not known in their own right as being at risk
- One adult not spoken to directly, and another has not had their voice heard
- Recognition of the vulnerability of adults who commit offences when they have also been identified as a victim on multiple occasions.
- Gap in information sharing with GP for one adult who would be having an annual health check so key information would knot be known.

Theme: Advocacy

None of the adults in this audit had an advocate and there is no evidence that advocacy has been offered to them.

If advocacy has been considered it has not been recorded.

This has been a recurring theme throughout audits this year.

Numbers of young adults under 25 being referred to advocacy is low.

Recommendation that this becomes a priority for SAB for 2025

To make a referral for advocacy in South Gloucestershire contact Voiceability. Click this box to see the services they offer

Use of advocacy is a recurrent theme in SAB audits we would like to know more about this and make it better– please click this box to complete a short survey

You can still request an advocate for someone who has capacity – always consider this

Think about language when recording – this audit found the use of the terminology 'catfished' which could minimise the impact of the abuse/ deception that took place

Anyone can call a multi agency meeting – always consider if this would help

There was learning for this audit that children's services should always be included when auditing on the theme of transition

What Good Practice did we see?

- Voice of the adult heard for four adults
- Good relationship with mental health practitioner
- Care leaver has a personal adviser (PA) however no evidence that other practitioners were working with the PA, or considering join up
- Good use of DASH
- Strong evidence of multi agency working for some of the adults

Click these circles for more information

Care Leaver Offer and information – **Click here for information**

Self Neglect Bitesize sessions include info about calling a multi agency meeting **Click to book**

Organisations that audited their involvement with the six adults were: Adult Social Care, Sirona, Police, GPs, DHI, Bromford & Voiceability

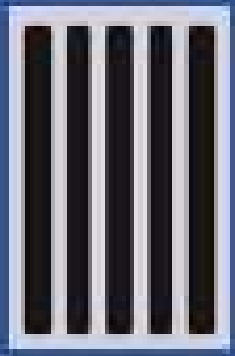
Adversity & Trauma - ACEs?

Verbal abuse
Emotional abuse

Physical neglect
Emotional neglect

Parental substance misuse

Physical abuse



Parental criminal behaviour and/or incarceration

Domestic abuse

Sexual abuse

Loss of a parent (death or separation)

Parental mental illness

Disguised Compliance?

Non engagement

or

Avoidant behaviour

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Disguised Compliance?

Disguised compliance involves parents and carers appearing to co-operate with professionals in order to allay concerns and stop professional engagement (Reder et al, 1993).

Important that practitioners can recognise disguised compliance, establish facts and gather evidence about what is actually happening in a child's life.

Keep an open mind!

Be Curious – Non-Engagement – Avoidant Behaviour?

The increasing ease with which the **label** 'disguised compliance' is used puts the **focus on parents as the problem**, rather than encouraging professionals to think about a **two-way relationship** and their behaviour in it.

(Forrester et al 2012 – Parental resistance and social worker skills: Towards a theory of motivational social work)

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Identifying Disguised Compliance?

- Conflicting accounts of family life from family members
- Presentation and behaviour of children conflicts with adult accounts
- Repeat incidents of harm/neglect to children
- Conflicting accounts/ evidence from different professionals

- Analysis of details, multi-agency chronology
- Conflicting accounts from neighbours
- Observation of parent child interaction (convincing evidence that simulated sensitive parenting is difficult to sustain C4EO 2010)
- Dependency
- Closure
- Flight
- Persistently unmet needs of children

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Safeguarding CHILDREN e-Academy

Sue Woolmore

Dealing with Disguised Compliance

VIRTUAL COLLEGE

South Gloucestershire Children's Partnership
Learning from Rapid Review
April 2021
Family D

The Children's Partnership held a multi agency rapid review to look for learning on 26th April 2021.

Who are Family D?

Family D are a mum and two children. It has been widely reported in the media that mum and the youngest child were murdered in Scotland, and the older child survived. This learning brief does not relate to the investigation into what happened in any way, but looks simply at learning for professionals and organisations

Professionals from 15 different agencies took part in the review

Theme One: Professional Curiosity

What did we learn?

- Information taken at face value
- Process driven work without looking at wider picture
- Not enough consideration given about ways to contact a parent when details are not on the system
- Lack of curiosity shown when exploring the vulnerability of an adult

What should we do differently?

- Ask further questions, be nosy, explore what is happening. Be careful not to simply accept what is happening without thinking about why it is happening
- Make sure you hear the voice of the child and all key people in the child's life, don't rely on one person's view
- Explore what a day in the life of the person you are working with is like

If my work comes to an end – who else needs to know what I know?

When English is not the first language, always consider use of interpreters

Seek evidence of Parental Responsibility

Be a curious practitioner

Theme Two: Working Together

What did we learn?

- Not all professionals knew who else was involved and didn't know about the Child in Need plan
- The professionals who saw the family most, had the least contact with other organisations
- Information was not shared as well as it could have been

What should we do differently?

- If you undertake an assessment think about who else should be told of the outcome, and who needs this noted in records
- At a transition point – for example changing school, closing a support package, change of team or service. Make sure other professionals know what is happening and share safeguarding records so that information is not lost
- Speak to families about who else they are working with

Theme Three: Parental Responsibility

What did we Learn?

- Evidence was not always sought to check who does and does not have Parental Responsibility (PR) for a child

What should we do differently?

- Make sure this is routine practice, and that confirmation of PR is always seen

Evidence of Good Practice

- Speedy assessment by Social Care, and quick practical support
- Swift move to locality social work team.
- Appropriate DVA coding on GP records for the family
- Good communication and relationships with education settings
- Additional resources, including a laptop, provided for home learning during covid
- Support for immigration status
- Regular contact from multiple agencies
- Good communication between agencies when unable to make contact
- Good multi agency response to missing episode

Theme Four: Children and Domestic Abuse

What did we learn?

- Two children left the home with their mother and were provided with emergency accommodation following a disclosure of domestic abuse, but there were other children in the home who remained.
- The remaining children were not considered by police or subsequently by children's social care despite living in the same house and witnessing the same incident.
- Lack of voice for mum in family court process

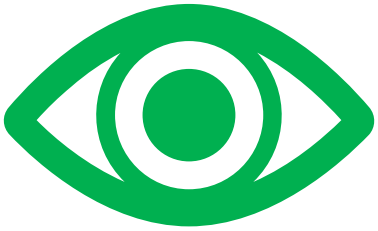
What should we do differently?

- Consider the impact of domestic abuse on all children within the family.
- Remain curious even when another agency has already made an assessment of risk
- Ensure all appropriate information is available to court, especially relevant while case are being heard in a virtual space and ensure parents are aware when the case is happening

What is happening Now?

There is a single agency and a multi agency action plan to ensure the learning identified throughout this process is acted on in a timely manner. This is being monitored by the Child Safeguarding Practice Review Sub group on behalf of the Executive of the Children's Partnership.

Top Tips – Professional Curiosity



See It

Hear It

Explore It

Check It

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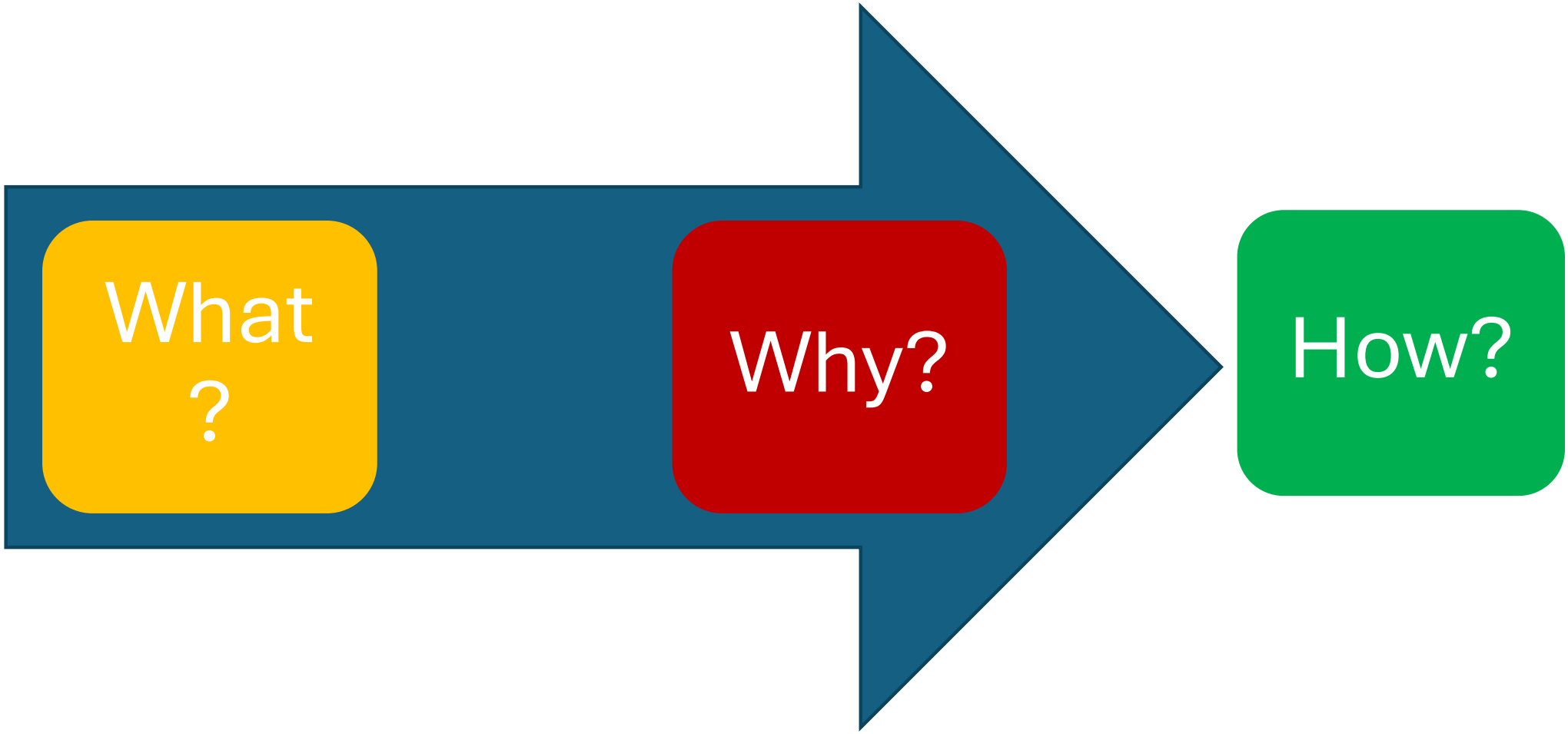
Professional Curiosity, Challenge & Courage



South Gloucestershire CHILDREN'S PARTNERSHIP

South Gloucestershire Children's Partnership
Child Safeguarding Practice Review
Family A
January 2023

The Children's Partnership commissioned Nicki Pettitt, an independent reviewer to lead this CSPR

Professionals from all of the involved agencies took part in the review

Members of the family also contributed their views to the CSPR

Family A
The South Gloucestershire Children's Partnership agreed to undertake a Child Safeguarding Practice Review (CSPR) by considering the engagement of professionals with a family of three children who are anonymised as Family A.
When the children were under 5 years old, their father died and their mother has been convicted of his murder. At the time of their father's death, the children were on child protection plans and a decision had been made to implement the Public Law Outline due to concerns about domestic abuse, the impact on the children of the parent's poor mental health and substance misuse, and the emotional neglect of the children.

Recommendations
1. SGSCP considers the practice briefing on safeguarding children in families where there is domestic abuse that was commissioned following the National CSPR 'Child Protection in England' to align learning
2. Consider the learning from this CSPR in the review of Domestic Abuse Training that is underway
3. All agencies review paperwork to ensure all GPs for the family are recorded and that relevant information is shared with them all
4. Partner agencies provide assurance regarding what they are doing to promote the Domestic Abuse Act 2021 in respect of children as victims of domestic abuse
5. Consider making 'including fathers as equal parents' a priority for 2023 onwards
6. Share this CSPR with Safeguarding Adults Board and Community Safety Partnership with a view to considering commissioning of services for lower level perpetrators of Domestic Abuse
7. Information about orders or plans in respect of Domestic Abuse (e.g. MARAC and DVPOs) are shared with all professionals working with children in the family, and that the MARAC plan and any plan/s for the children reflect and compliment each other
8. SGCP considers how it can ensure that professionals in all partner agencies are aware of the responsibilities for and services available to care leavers

Theme: Working with Fathers
- Fathers need to be fully considered in assessments and plans
- There is routine questioning for women about Domestic Abuse, but this doesn't happen for men
- There were opportunities for improved professional curiosity about Domestic Abuse in respect of Father in this case

Theme: Full understanding of family history is needed for an assessment:
- Impact of childhood trauma needs to be considered in assessment by any agency.
- Practitioners need to be curious about multiple presentations and what lies behind this and not treat incidents in isolation
- Vulnerabilities need to be explored, mental health, drug or alcohol misuse, domestic abuse, being a care leaver

Theme: Domestic Abuse
- Making assumptions about who is the victim and who is the perpetrator in a family can lead to ineffective plans
- When there are claims and counter claims it is vital to unpick 'who does what to who'
- Understanding the power dynamic is crucial
- Building a good relationship - trust is key to effective working

Theme: Remain child centred when there are dominating parental factors
- Consider what a day in the life of this child is like
- Be aware that a child's behaviour may be their 'voice'
- Recognise and challenge child blaming language

Click here to see resources about Domestic Abuse and links to MARAC

Couples in an abusive relationship sometimes decide not to separate and safety planning needs to happen

The policy of separate and isolate does not always work

Evidence of Good Practice
- The Transitions team are providing Freedom Programme work with a group of care leavers as a preventative measure. This is good practice and consideration should be given to widening this approach
- Parent Link worker at the school has been consistent and attended core group meetings and had regular check-ins with the child at school and continues to do this now
- Support is available to care leavers until the age of 25, and this is good practice and responsible corporate parenting

Mother told the review that the requirement to separate from her partner meant she had to be secretive and could then not ask for help or be honest with professionals in case she would 'lose' her children

You can read the full CSPR Family A by clicking here

Unseen Men – Learning From Case Reviews

- A lack of professional engagement and curiosity
- An over-focus on the quality-of-care children receive from their mothers
- Inadequate information sharing between services

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Working with Fathers

Including Fathers – Self Assessment Checklist

This guide provides the key descriptors of evidence-based ways of working with fathers/male caregivers. This can include partners, stepparents, males in same sex partnerships and any male with caring responsibilities in the child's life. It is a self-assessment and planning tool, the outcome of which should lead to a clearer and shared understanding of the current ways of working with fathers within an organisation or service and what steps need to be taken to progress.

This tool is available here.

There is also a video to support this which is available here.

Downloads

Working with Fathers

Concerned about a child?

01454 866000 - Monday to Friday

01454 615165 - Out of hours/Weekends

In an emergency please ring **999**

Bath & North East Somerset Community Safety & Safeguarding Partnership and South Gloucestershire Children's Partnership

Child Safeguarding Practice Review
Baby M

April 2023

The two Partnerships commissioned Sarah Holtam, an independent reviewer to lead this CSPR

Professionals from all of the involved agencies took part in the review

Members of the family also contributed their views to the CSPR

Baby M

The reason for this Local Child Safeguarding Practice Review (LCSPR) is to consider Baby M, a three-month-old baby who experienced serious and significant injuries, thought likely to be to be non-accidental.

The review analysed a ten month time frame from the booking in appointment with midwifery services to the date of the injuries occurring.

Baby M's mother moved between two geographical areas during this time frame and both partnerships worked together to undertake the review.

Following birth, Baby M was discharged with both parents to the paternal family home in Bath & North East Somerset.

Baby M's mother returned to South Gloucestershire to live shortly before the injuries occurred and Baby M remained in the paternal family home.

Recommendations

There are four main recommendations each with a series of actions relating to each theme.

1. Health Recording Systems include a holistic assessment of a child's needs which includes contextual maternal and paternal family factors
2. The ICON Programme & increasing awareness of Non Accidental Injury in Babies
3. Effective Transfer of Information between areas and services
4. Safeguarding Supervision arrangements for community health professionals which ensures there is a safe space for critical thinking in practice, promotes professional curiosity, and is a trauma informed approach to the family's needs when working with pre and post birth situations

Theme: Keeping a focus on the child when they move between areas

- It was not clear where Baby M lived, agencies were reliant on what and when parents told them
- There wasn't enough curiosity about where Baby M was
- Information sharing was too variable between areas and health services and with housing providers. More collaboration was needed
- Practitioners should ensure housing providers are kept in the loop with key information and included in multi agency discussions

Theme: Critical thinking in Practice

'On the face of things' all appeared well for Baby M

- It is vital to understand the narrative of a baby's lived experience. What is the day in the life of a child like?
- Inquisitive, open minded practice ensures a holistic view of day to day life
- Lack of multi agency information sharing and decision making contributed to Baby M remaining at a universal support level

Theme: Identifying and Responding to the vulnerability of babies

- Increasing awareness of the ICON programme to all practitioners including those outside of health providers
- Ensure physical health needs for a baby are balanced with understanding of wider factors, including parental needs, past trauma to gain a comprehensive picture

Records need to be clear, accurate and specific so that when information is shared it is understood correctly

ICON Resources are available by clicking here

You can read the full CSPR Baby M by clicking here

Theme: Recording systems

- Different pieces of information were seen in isolation, language and behaviours of parents and information about the past were not joined together
- Record keeping was poor at times with limited details
- Language used to describe situations was factually incorrect at times and did not distinguish fact from opinion or was not specific enough to describe what was being seen.

Understanding Wider Context in a Family

- One of Baby M's parents was a care leaver and the impact of this wasn't explored
- Family dynamics were not explored, including coercion and control that had been witnessed
- Housing vulnerabilities were not considered

BCSSP

Bath & North East Somerset Community Safety & Safeguarding Partnership

South Gloucestershire Children's Partnership

Child L

Learning identified at a multi agency event
12th July 2023

Child L is a baby under one who has suffered injuries thought to be due to physical abuse with concerns about faltering growth

Theme: Response to Bruising in Non-Mobile Babies

What is working well?

- Bruise identified and CP medical took place
- Non mobile baby checks took place, Child L followed the protocol
- Assessment went ahead by children's social care

What are we worried about?

- NSPCC referrals happened prior to medical but not showing on all records
- Gap in information that was shared with the referrer
- Differing accounts given about what happened to cause the bruise

What needs to happen?

When information is shared as part of non mobile baby checks each agency to clearly record what is shared and their analysis around this

Theme: Faltering Growth

What is working Well?

- Multi agency working between health visitor and social care strong with almost daily contact
- All South Glos professionals identifying concerns
- Curiosity and tenacity shown by professionals and information not taken on face value

What are we worried about?

- Clarity about who can weigh and measure babies. There is confusion about who is qualified/commissioned to undertake this and who should analyse this
- Child in Need meeting given a diagnosis from a consultant that there was a medical cause for Child L's growth, but there were differing views from medical professionals. Professionals felt unable to challenge
- Incorrect information sharing and missing information from other area about the child and whether Child L had a CP plan
- Rapid Access Clinic referral turned down
- Confusion about which teams would undertake assessments, across two regions.
- Continuity interrupted due to complaints by family and also family attending appointments in different places

What needs to happen?

- Pathway for children with faltering growth requiring regular weights to be clarified, including who is their lead health professional, and a resource and pathway established for weighing those children where there are high level concerns.
- Single point of contact/voice needed for social care

Theme: Multi Agency Working

What is Working Well?

- Unwavering focus on the child
- Engaged and consistent GP
- Maintained working relationships through challenge
- Evidence of professional curiosity
- Evidence based practice drawing on learning from previous CSPR, and use of tools

What are we worried about?

- Change in decision about whether to have a strategy discussion
- Escalation within timescales
- Cross border information sharing between areas

What needs to happen?

GP and other professionals can seek advice from Community Paediatrician, reminder needs to be given

Theme: Attempts to mislead professionals/Not following advice

What is Working Well?

- Tenacity of professionals, appropriate challenge
- Professional triangulation of information
- Housing officer asked to see Child L

What are we worried about?

- Unclear of impact of parental learning needs, and possible coercive control to Mum
- Parents refusal to accept support
- Over optimism about parenting abilities
- Parental avoidance of all professionals and lying to professionals at times

What needs to happen?

- Professionals need to ensure they link up with others who are working with the family, consider joint visits
- Remain curious and don't accept information on face value

Theme: Locations, Cross Border Work

What is working well?

- Escalation used correctly
- Kept sight of the child when he could have been transferred

What are we worried about?

- Incorrect Information sharing
- Housing had concerns in the other local authority, but hard to get the concerns shared in multi agency meetings
- Response to escalations

What needs to happen?

- Ensure the voice of practitioners who know the child/family well is heard to minimise risk of incorrect information

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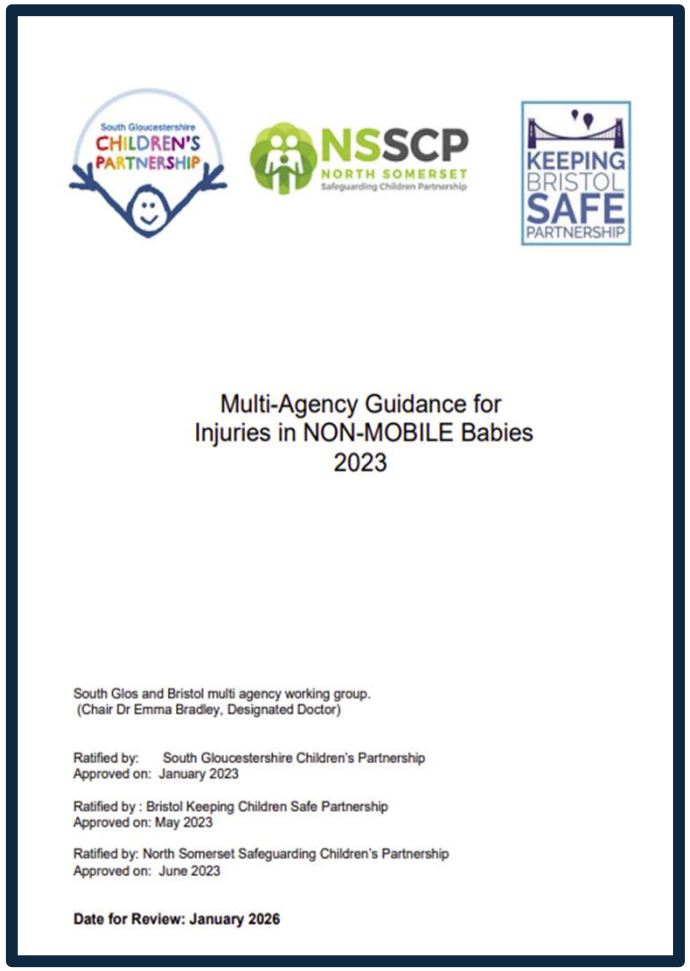
Injuries in NON-MOBILE Babies - 2023



Aim of guidance to ensure professionals

- Are aware that even minor injuries could be a pointer to serious abuse in non-mobile babies
- Know that such injuries, however plausible, MUST routinely lead to multi-agency information sharing
- Support professionals to identify potential concerns and make referrals as appropriate

Also read

- Guidance – Congenital dermal melanocytosis (blue spot marks)
- Addendum for Early years settings and Child Minders
- Parent leaflet + accessible version

South Gloucestershire Children's Partnership Reflective Learning Event April 2021 Harry

The Children's Partnership held a reflective learning event on 28th April 2021 facilitated by independent reviewer Nicki Pettitt.

Professionals from 9 different agencies took part in the review

Who is Harry?
Harry is a 15 year old boy who was involved in a knife crime incident. He received stab wounds. His injuries were serious but not life changing.
There is a regional thematic knife crime CSPR taking place across the region and Harry is part of that.

Theme One: Domestic Abuse

Headline learning – professionals to understand the long term impact of having witnessed DVA, and continues post separation and sometimes get worse

What did we learn?
The impact of witnessing domestic abuse for a child continues long after the incident is over, or the adults have separated and the abuse has ended.

What should we do differently?
- Work in a trauma informed way
- Look for reasons behind behaviour rather than just responding to what is happening
- Click anywhere in this box to find training about working with trauma

Theme Two: Working Together
What did we learn?
- We saw practitioners/organisations work in silos
- We saw professionals who held onto information that should have been shared

What should we do differently?
- Make use of multi agency meetings and multi agency chronology writing
- See children as part of a community as well as a family, assess in a more holistic way
- When you are not sure, and information doesn't seem to fit or there is ambiguity – get together to talk through what is happening.

Headline Learning: If a child has a significant long term professional in their life it makes a difference.

If there is an overdose of a prescription medication, emergency services/hospital A&E departments should always inform the prescriber, alongside other safeguarding referrals.

System review needed about how referrals are recorded about children who already have a young person support worker or social worker to ensure that key information is not missed

Impact of Domestic Abuse – what did practitioners see?
- Behaviours that would lead to being isolated at school, wanting to be isolated
- Vulnerable to exploitation - risk identified/ family disclosure but not shared
- Concerns about gangs
- Anxiety, soiling, hyperactivity
- Violent outbursts, history of physical and emotional abuse
- Suicide attempt
- Cannabis use from age 13
- ADHD
- Memory and vocabulary difficulties

A shared understanding of the whole picture would have helped to support Harry and his family effectively – work together with other professionals to see the whole picture

Agencies should 'flag' records when there has been a strategy or Section 47 enquiry

Click here for Domestic Abuse Training

Click here for Exploitation Training

Have exploitation in mind when working with young people – don't dismiss it.

Be a curious practitioner

Domestic Abuse continues post separation and sometimes gets worse

Have an open mind, think the unthinkable

Evidence of Good Practice
- School – flexible and supportive – bespoke education package is outstanding and did not PEX (permanently exclude) despite having grounds to
- CAMHS response in hospital after an overdose –asked for their referral to be looked at under a contextual safeguarding lens
- Mentoring has been really significant and identifying Harry's younger sibling for mentoring is good practice as early intervention
- Extended involvement of FYPS for Harry & his family
- Trauma informed outreach approach has been used by professionals

What is happening Now?
There is a Thematic Knife Crime Review underway in the region. This will gather the voice of children, families and practitioners.

South Gloucestershire Children's Partnership
Child Safeguarding Practice Review
Children Exposed to Serious Youth Violence
August 2024

The Children's Partnership commissioned Nicki Pettitt, an independent reviewer to lead this CSPR

Professionals from all of the involved agencies across 3 local authorities and Child T's family took part in the review

Child T

The South Gloucestershire Children's Partnership agreed to undertake a Child Safeguarding Practice Review (CSPR) to consider practice and systems when there are reasons to be concerned for a child due to their involvement in or exposure to serious youth violence (SYV). The decision to undertake this CSPR was because of the 2023 death from a stab wound of a child named Child T*. This review has also considered the available learning about the out of area children who have been convicted for killing Child T.

*anonymised for publication

Theme: Risk of SYV

- It is not only children with adverse childhood experiences who are at risk of involvement in SYV
- Child T came from a loving family home which gave professionals reassurance
- For Child T there were still indicators of risk even though he appeared to be doing well and there were no significant recent concerns
- Child T talked about the impact of living in certain postcode areas and becoming involved in SYV
- ADHD and anxiety were both factors for Child T

ADHD, school exclusions and exploitation are linked themes that have been highlighted repeatedly locally

1. The Partnership to ensure that a local critical incident plan is developed, with other partnerships in Avon and Somerset, using this case to inform its development.

2. That the National CSPR Panel requests that the correct government department/s consider the need for a national standard operational procedure for responding to a critical incident.

3.The partnership to request that the current status and terminology of MARM is changed to Child Protection Plan – Risk Outside of the Home (CP-ROTH)

4.That assurance is provided to the Partnership about the outcome of the PIMM review, as part of the wider independent review of the Risk Management Pathway

5. The Partnership to request that partner agencies consider how they will support staff to ensure that child victims of exploitation are prevented from being 'criminalised'.

6.That the partnership seek assurance in respect of the development of the work of the Violence Reduction Partnership (VRP) in South Gloucestershire and the wider Avon and Somerset VRP in respect of their response of serious youth violence. This should include:

- Consideration given to how information on specific children, including investigations, intelligence, locations, and perpetrators is shared regularly across the five Avon and Somerset areas.
- Consideration given by the Pan Avon and Somerset Needs Assessment for SYV to the importance of working with and sharing information with areas outside of Avon and Somerset, including Wiltshire.
- Consideration of the impact of the Online Safety Bill 2023 across the system.

Bitesize Exploitation sessions cover PIMM, MARMM and South Glos processes – click here to book a free place

System wide issue that there is a lack of understanding that a MARMM is equivalent to a Child Protection

Access Modern Slavery training by clicking here

Theme: National Referral Mechanism (NRM)

- An NRM is used when there may be criminal exploitation/trafficking
- A referral was made in respect of Child T in 2021 – which is expected practice for a child known to have carried a weapon
- This was a missed opportunity to provide focussed support and should have been coordinated with the professionals who Child T knew
- Anecdotal findings suggest take up of Modern Slavery training which includes NRM is poor.

Theme: Drill Music

- Child T was emerging as a popular drill artist on YouTube
- It can increase the risk of becoming target of violence due to the nature of the threats in the music.
- Professionals need to be aware of the content of drill music for those involved when making their assessments.

Theme: Extra Familial Harm

- There has been a shift, locally and nationally, for children at risk of exploitation to have focus on risks outside the home
- A system that focusses only on risks outside the home is vulnerable and it is vital to also consider risk within homes

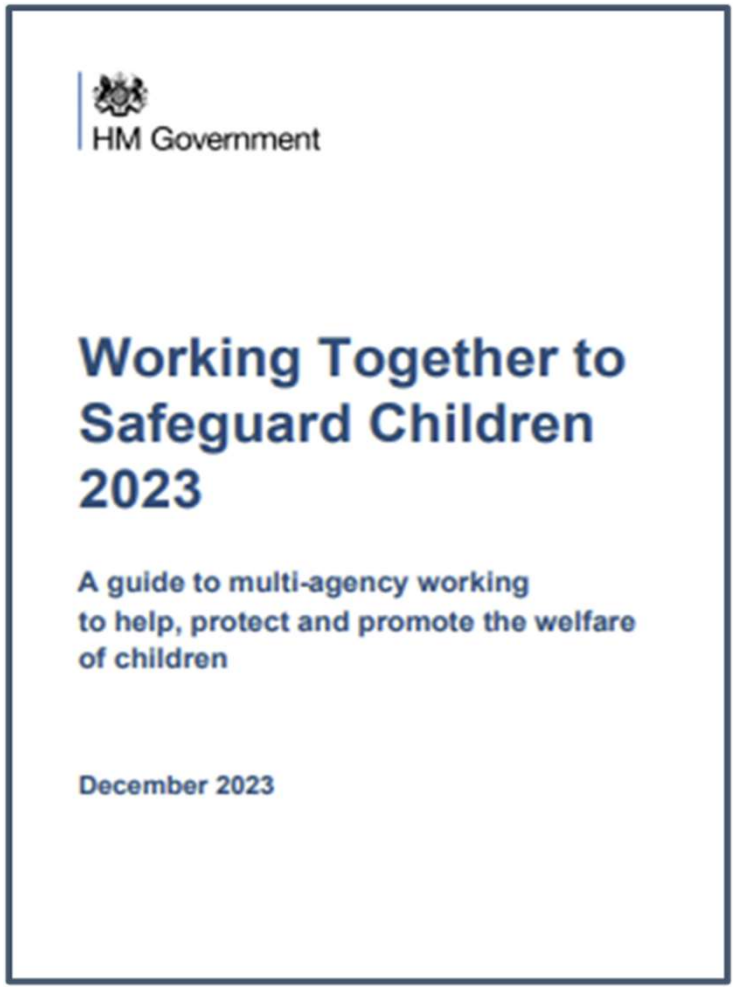
Evidence of Good Practice

- **Exploitation Identification tool had been regularly updated**
- **PIMM has consistent and committed membership who work well together and share information effectively**
- **Child T's school worked well with him and his attendance increased dramatically – he was settled and took some GCSEs there although this should have been a short stay provision.**
- **There was good support planning for Child T's future he met the careers advisor around 20 times**

There is an identified need for a clear and effective serious incident response across Avon & Somerset which can be used out of hours

You can read the full CSPR by clicking here

Updated Statutory Guidance 2023



Emphasis on:

- Strong multi-agency relationships…to offer ‘tailored’ support
- Early Help – Risk factors to be considered (Early Help Guide)
- Safeguarding S17 – A wider range of professionals can be the ‘lead professional’
- Children with disabilities – Social Care role clarified
- Considering risks children face outside of the home

South Gloucestershire CHILDREN'S PARTNERSHIP

Safeguarding Definition 2023

Providing help and support to meet the needs of children as soon as problems emerge

Protecting children from maltreatment, whether that is within or outside the home, including online

Preventing impairment of children's mental & physical health or development

Ensuring that children grow up in circumstances consistent with the provision of

safe & effective care

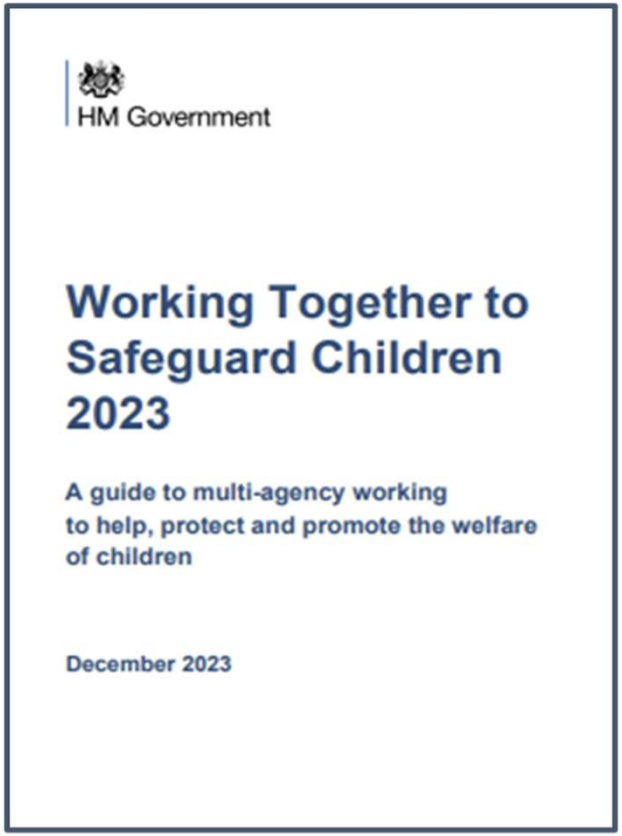
Promoting family & kinship upbringing where that is in the best interests of the children

Taking action to enable all children to have the **best outcomes** in line with the Children's Social Care National Framework

South Gloucestershire CHILDREN'S PARTNERSHIP

Responsibilities ?

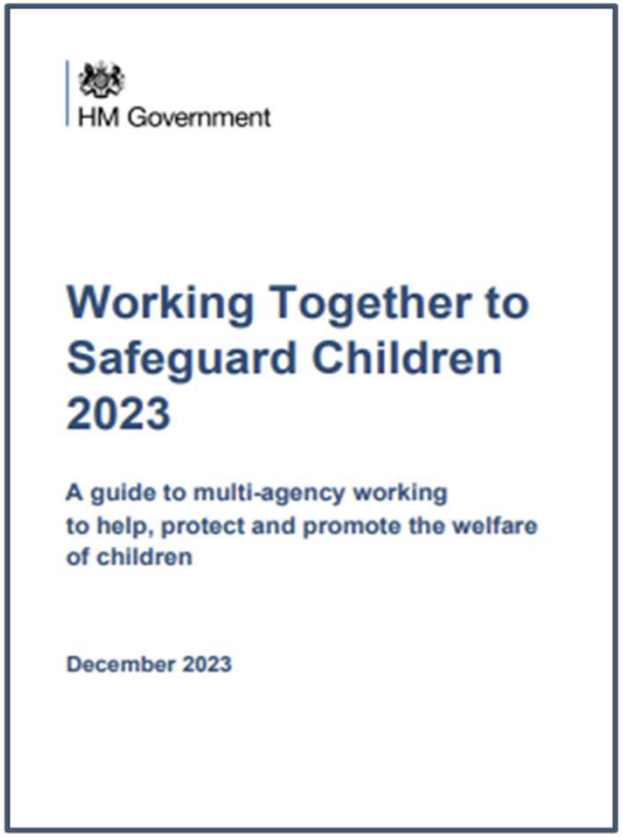
3 Statutory Partners + Relevant Agencies



South Gloucestershire CHILDREN'S PARTNERSHIP

What have children said they need from us?

- Vigilance
- Understanding & Action
- Stability
- Respect
- Information & Engagement
- Explanation
- Support
- Advocacy
- Protection



South Gloucestershire CHILDREN'S PARTNERSHIP

Created by the Compass Team May 2021

The importance of the child's voice

Why capture the views of the child

- It's about them - they are the experts!
- To capture the perspective of the children, parents and other family members.
- The child's views are important to support "buying in" to the concept of change.
- The child's voice should be captured within all assessments.

Why is it important to capture the voice of the child?

- Children should be heard and have the right to make decisions about changes in their lives.
- The right for a child to be listened to and heard is listed in UN convention of rights and the Children's Act 2004 emphasises the importance of speaking to a child to gather their views for assessments.

Who should capture the voice of the child?

- The key is someone who has a trusted relationship with the child.
- The quality of the child's voice captured depends on the quality of the relationship.
- If the relationship is strong the voice captured will be stronger and vice versa.

What is the information used for?

- To inform and plan the next steps.
- To improve the current situation for the child, young person and/or family.
- To ensure parents and professionals are aware of the child/young persons thoughts, feelings and wishes. Which is essential to everything we do.

How to get voice of child?

- The child's voice can be captured through conversations, 1:1 work, activities, worksheets, questionnaires, and artwork. Compass can provide suggested resources.
- Children who are young, non-verbal or have a disability can express their views being creative i.e. observing their play, body language, facial expressions, we can interpret their understanding of their choices, preferences, likes, dislikes and what motivates them.
- All activities can be uploaded to support the EHAP.
- EHAP's can be strengthened by using direct quotes. Using direct quotes will amplify and make comments explicitly clear.

When should we capture the voice?

- If you are thinking about completing referral.
- For initial EHAP'S.
- During EHAP reviews.
- When closing the EHAP.

South Gloucestershire CHILDREN'S PARTNERSHIP

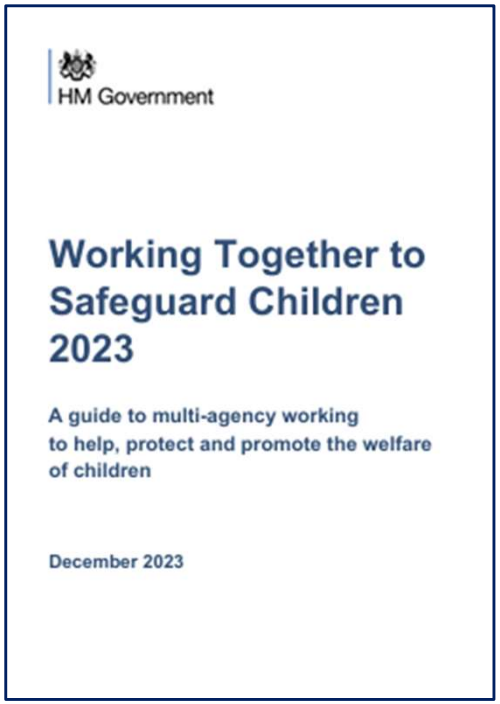
South Gloucestershire Council

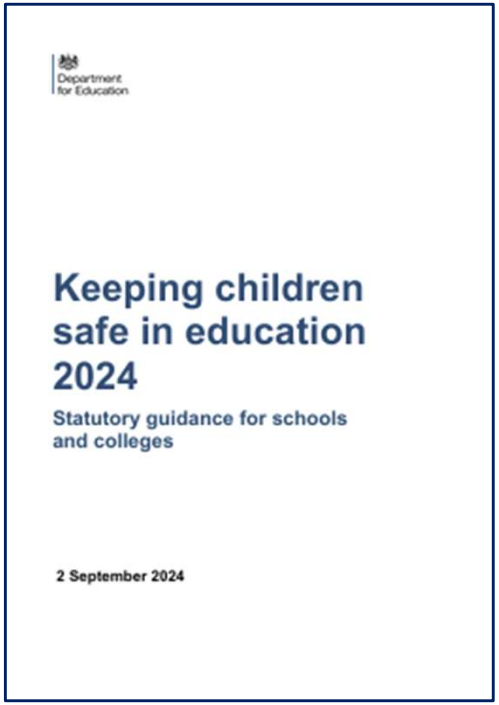
South Gloucestershire Children's Partnership

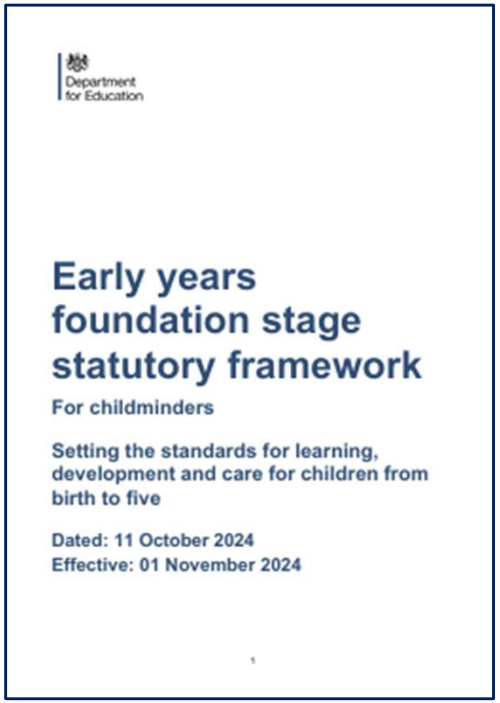
The right help, in the right way, at the right time

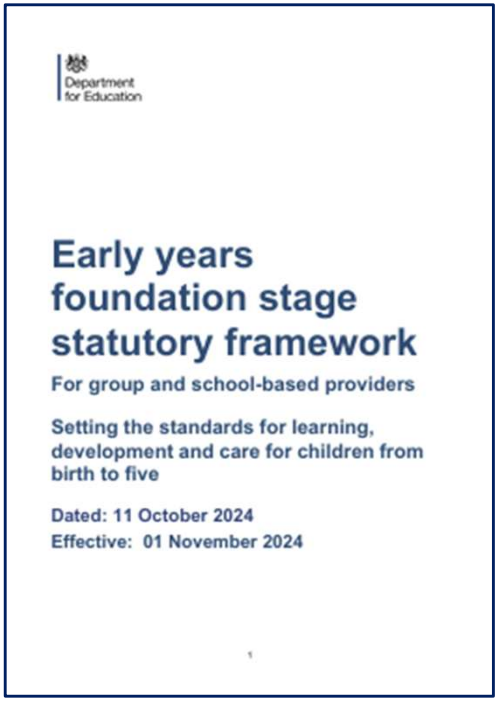
November 2023

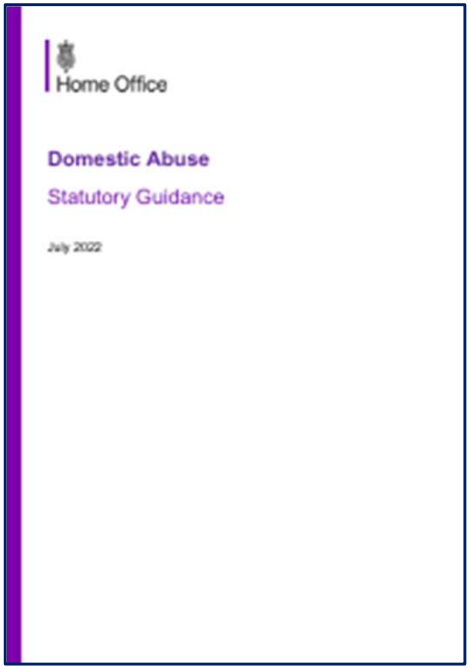
Guidance



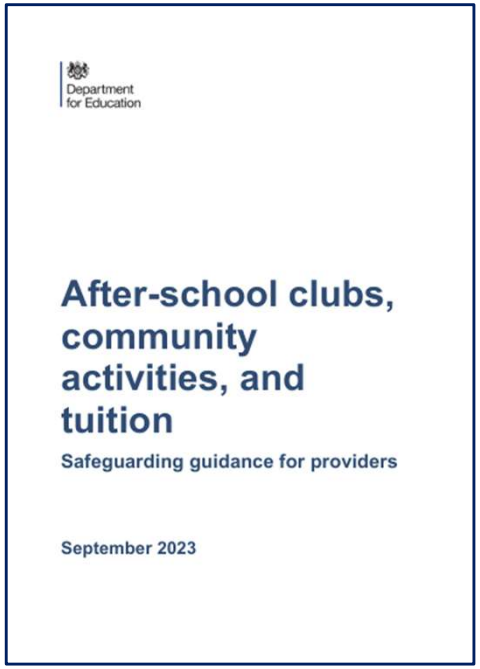


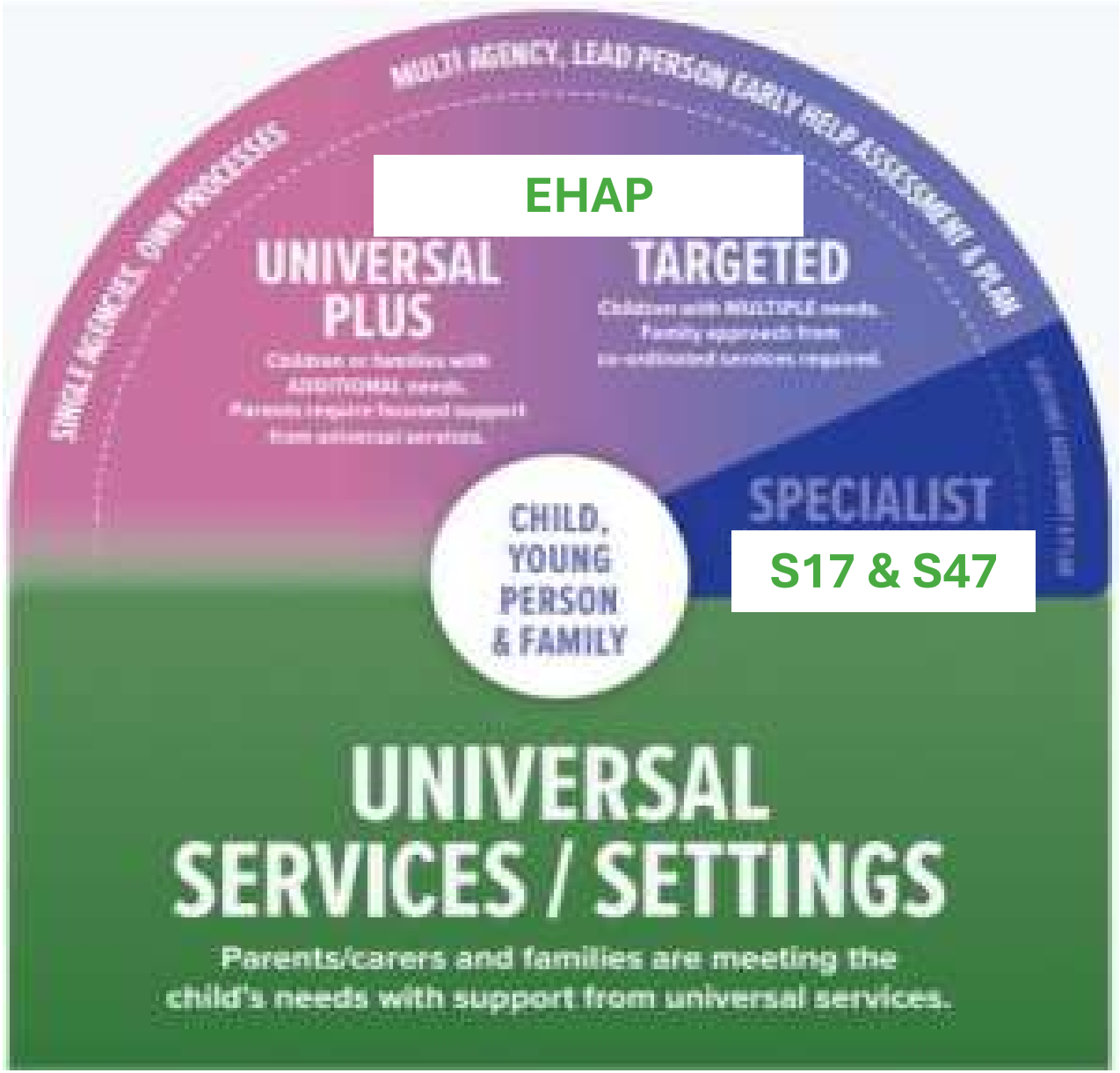






South Gloucestershire CHILDREN'S PARTNERSHIP





Right Help, Right Way, Right Time….

Graduated tiers of help and support.

‘Response to Levels of Need’

South Gloucestershire CHILDREN'S PARTNERSHIP

Referral Form – Updated Jan 2025

Request for Help Form

South Gloucestershire Council

This form needs to be completed in order to request support from **all** Local Authority services, **including Preventative Services and Social Care.** If you have an immediate safeguarding concern, please call the Access and Response Team (ART) on 01454 866000.

Before completing the form, please ensure that you have consent from the parents and Young People over 11 years and that they are aware of the information being shared in the referral and what is being requested. You also need to gather the thoughts and views of the parents and children/young people. Best Practice would be to show a copy of this referral to parents so they are clear about the information you are sharing unless to do so would place a child at risk.

When requesting support from Early Help or Preventative Services, **please consider the questions below** before completing the Request for Help form:

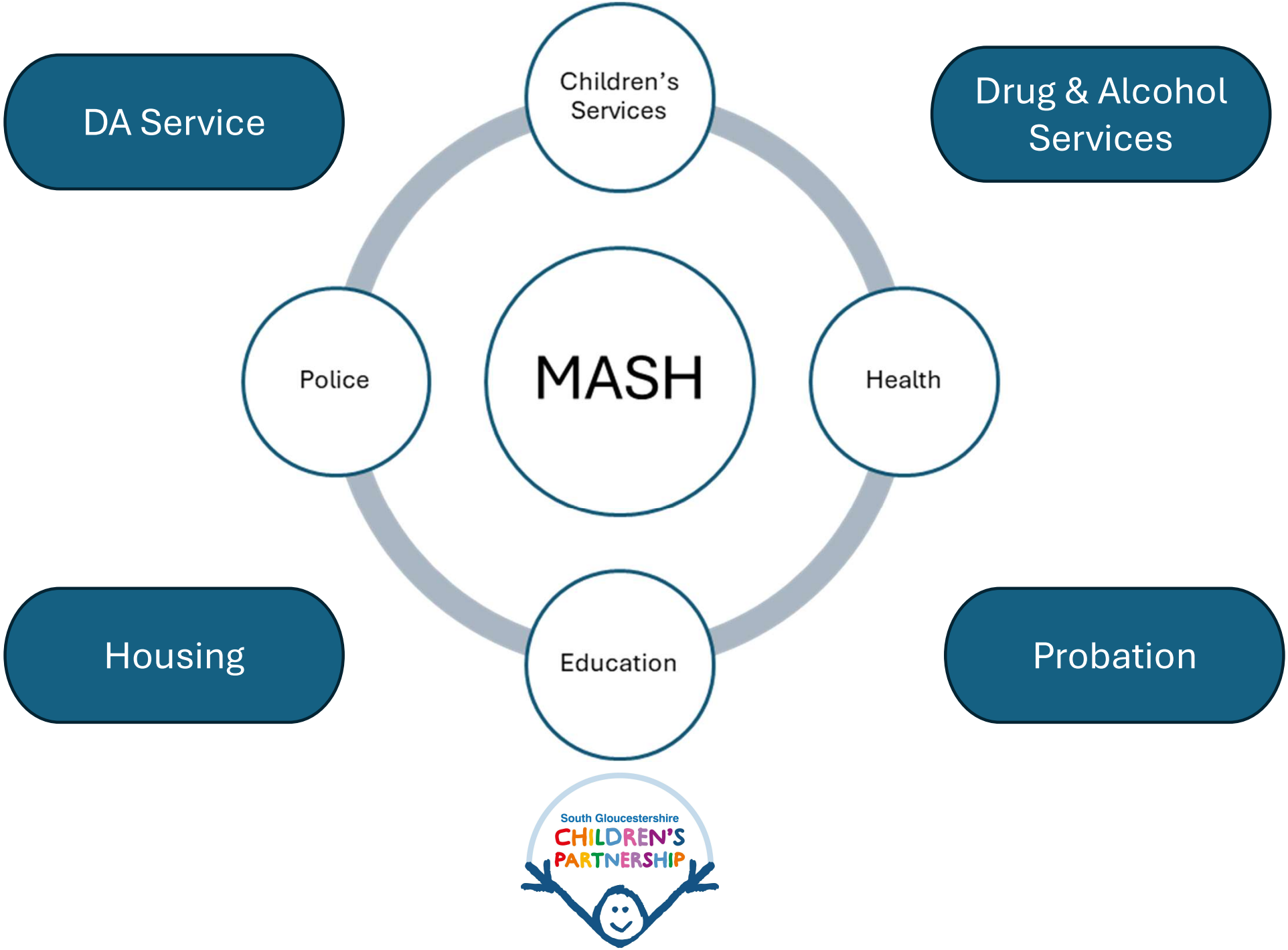
- Have you spoken with Compass before making this referral? email Compass@southglos.gov.uk
- Is there an **EHAP (Early Help Assessment and Plan) open for this family?** If not, please discuss with **Compass** prior to making this referral
- Have universal services/support been tried in the first instance?
- Have you referred to the SEND Local Offer?
- https://find-information-for-adults-children-families.southglos.gov.uk/kb5/southglos/directory/localoffer.page?localofferchannel=0&channel=localoffer
- Have you looked at the South Gloucestershire Children's partnership: The Right Help in the Right Way at the Right Time (Threshold Document)? http://sites.southglos.gov.uk/safeguarding

Referral Information –

Referral Date	
Organisation	

Referrer Name	
Phone:	
Email:	

MASH Partners



BRAG Rating & MASH Explained

RAG Rating	Outcome	Response Time Target	MASH
Red (Priority) **Acute Child Protection** Requires intensive support.	Section 47 / Child Protection	4 hours – 0 day	No
Amber **Complex / Child In Need** complex needs likely to lead to longer term intervention.	Child In Need Assessment	1 working day	Do we need **more than one** professional opinion to make a decision? If no, progress through normal channels If **yes, progress to MASH**
Green **Vulnerable** Universal support and early help services	Early Help Assessment	3 working days	Could do, do we need **more than one** professional opinion, evidence is it is low level. **If so, progress to MASH,** if no progress through normal channels.

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Early Help Assessment & Plan

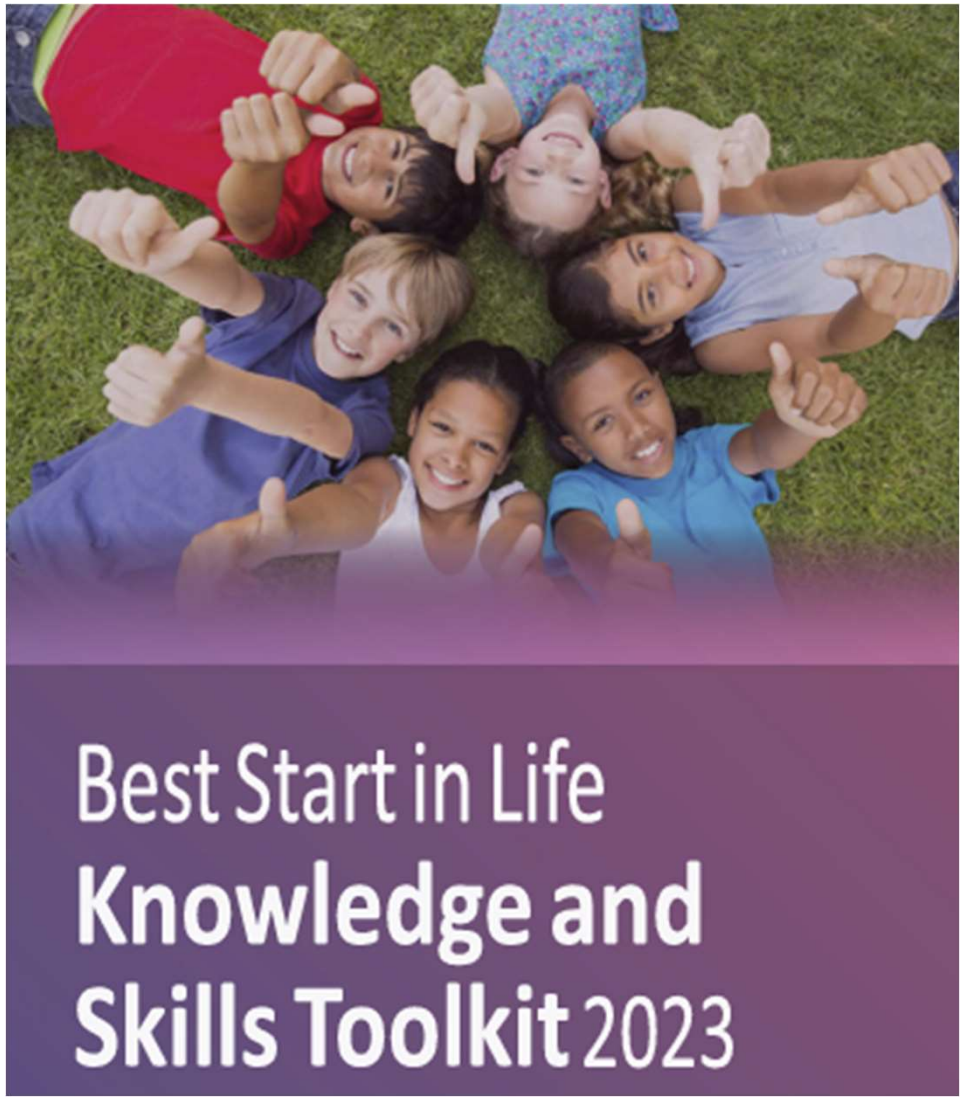
Priority 1 – Early understanding of the diverse needs of children, young people, and families

Priority 2 – Access to information , advice, guidance, opportunities, support and signposting within the local community.

Priority 3 – Effective partnership responsibility, response and accountability.

Priority 4 – Co-ordinated planning and provision of support

Priority 5 – Demonstrate a positive impact on the lives of children, young people and families.



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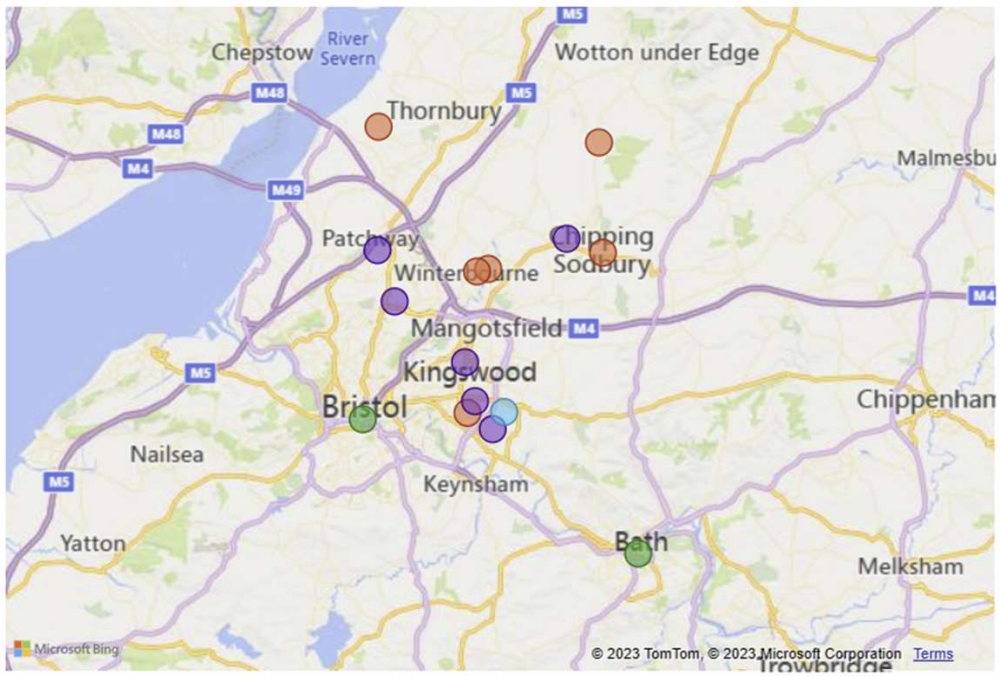
South Gloucestershire Council Mapping Tool – Early Help

Map of services



Service Function

Search

- [ ] Select all
- [ ] (Blank)
- [ ] Borrow Items
- [x] Breakfast Clubs
- [ ] Breastfeeding Support
- [ ] Childminder
- [x] Children's centre
- [ ] Community Centre
- [ ] Community Welcome Spaces
- [ ] Dentist
- [x] Domestic Abuse
- [x] Drugs & Alcohol support
- [ ] Education (not schools)
- [ ] Financial Services and Advice
- [ ] Food Support & Food Banks
- [ ] Full Day Care
- [ ] GP Surgery
- [ ] Health & Medical
- [ ] Holiday Scheme
- [ ] Home Childcarer

South Gloucestershire Council

Town

Search

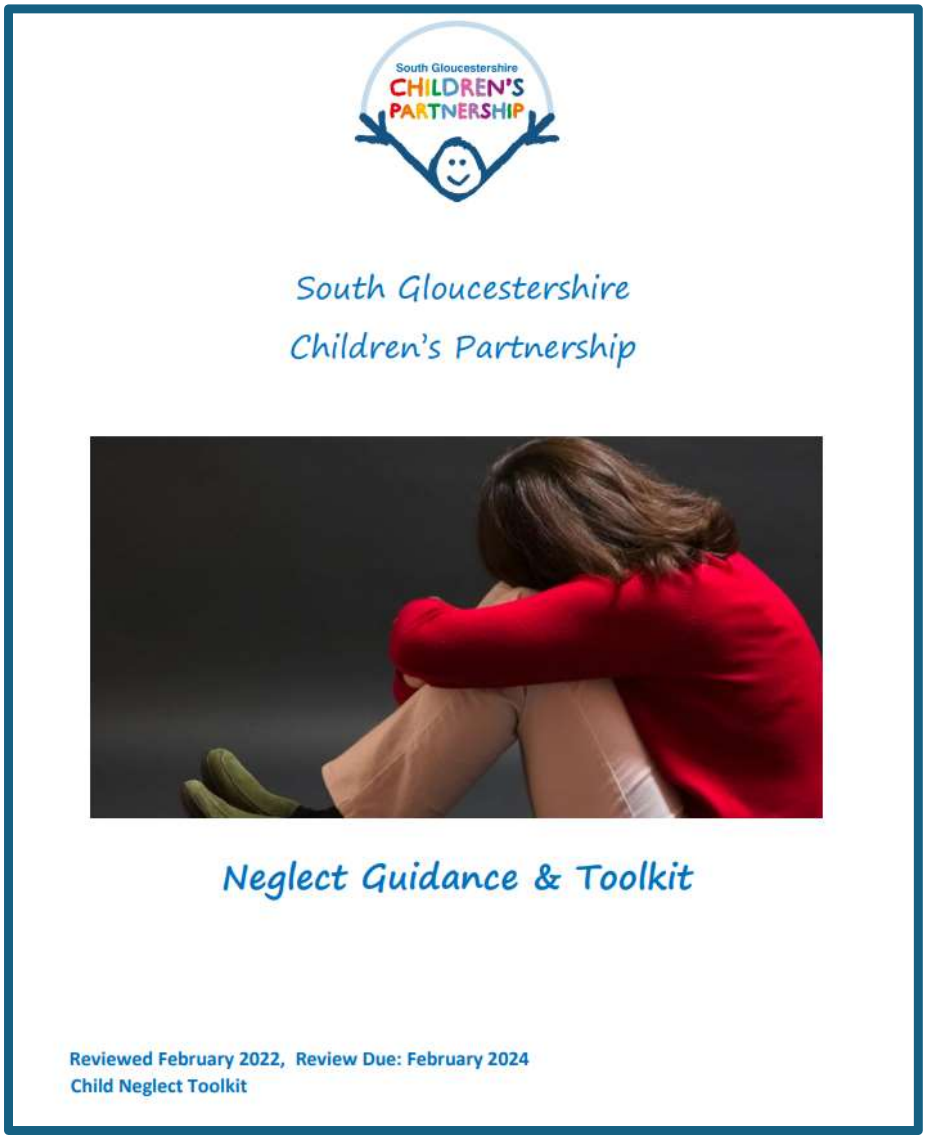
- [x] Select all
- [x] -
- [x] Kingswood
- [x] Bath
- [x] Bristol
- [x] Cadbury Heath
- [x] Chipping Sodbury
- [x] Filton
- [x] Frampton Cotterell
- [x] Patchway
- [x] Staple Hill
- [x] Thornbury
- [x] Warmley
- [x] Wickwar

Cluster

- [x] Select all
- [x] 1 (Thornbu...
- [x] 2 (Patchwa...
- [x] 3 (Winterb...
- [x] 4.5 (Kingsw...
- [x] 6 (Staple Hi...
- [x] Service sup...

NOTE: Only services with post codes appear on map (above). List view (below) shows all services including online services

Service Name	Function	Contact number	Email	Website	Address Line 1	Pos
Cadbury Heath Children's Centre	Children's centre	01454 862974		Link	Parkwall Primary School	BS30
Developing Health and Independence (DHI)	Drugs & Alcohol support	01454 868750 or 08000733011	info@dhisouthglos.org.uk	https://www.dhi-online.org.uk/get-help/adult-drug-alcohol-treatment/south-gloucestershire-drug-and-alcohol-service	Developing Health and Independence (DHI)	BS30



Aims to:

- highlight difficulties experienced when working to combat neglect
- suggest ways to avoid or resolve them
- support the use of professional judgment at all stages during interventions with families

Information Sharing

The Data Protection Act 2018 & GDPR supports the sharing of relevant information for the purposes of keeping children safe

'Legal Obligation' or 'Public Task' (Public Interest)

Data Protection Act - processing condition that allows practitioners to share

Special Category Personal Data

(Sensitive = More protection needed GDPR Article 6 & Article 9)

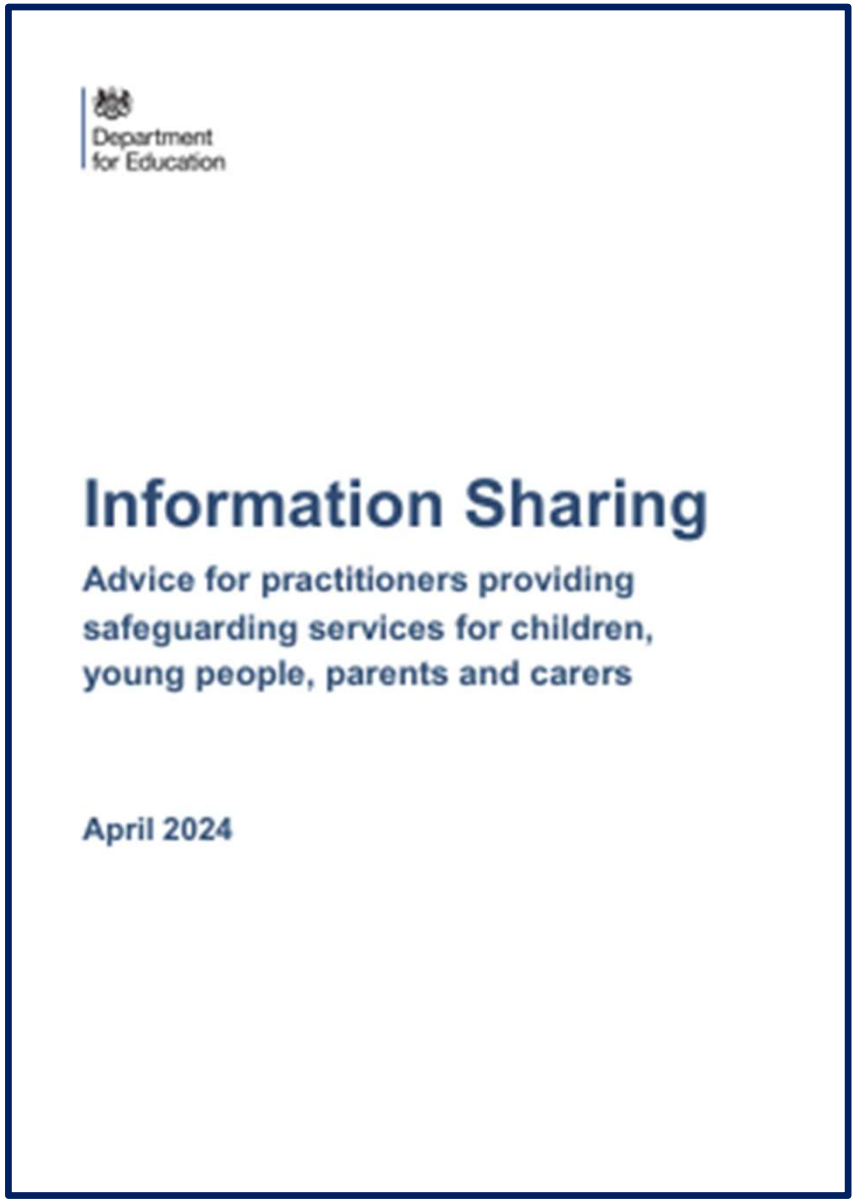
when

'Safeguarding children and individuals at risk'

This allows sharing without consent, where consent cannot be reasonably gained or if to gain consent would place a child at risk

South Gloucestershire CHILDREN'S PARTNERSHIP

Necessary
Proportionate
Relevant
Accurate
Adequate
Timely
Secure



South Gloucestershire CHILDREN'S PARTNERSHIP

Professional Differences ? What if I don't agree?

South Gloucestershire Children's Partnership

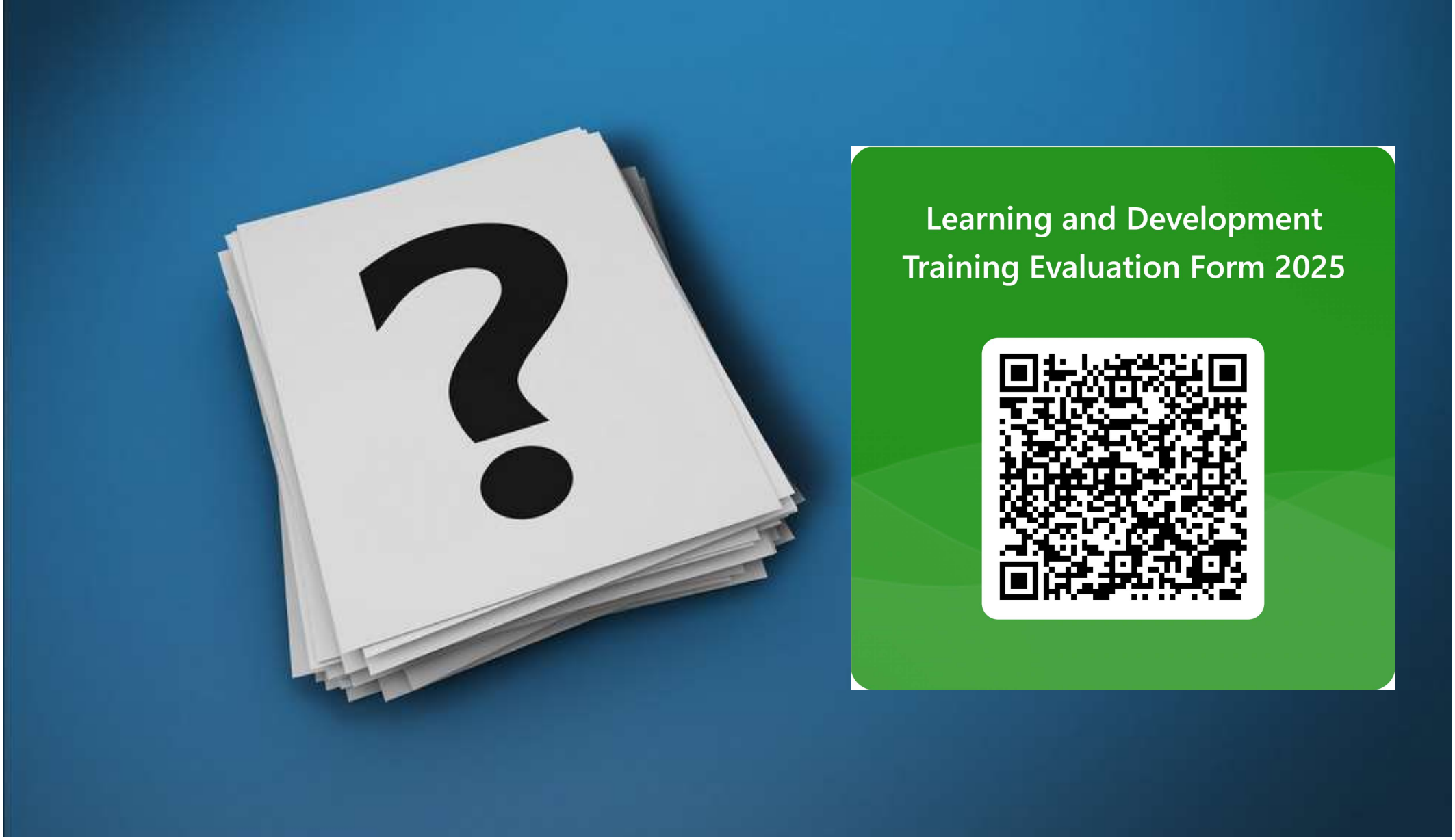
Resolution of Professional Differences

(Escalation Policy)

The aim of this policy is to provide a clear mechanism for the resolution of professional differences in order to ensure a timely resolution that ensures that the needs of the child or young person are met.

It provides a local process to be followed. SGCP see challenge as a key part of effective and healthy inter-agency working cultures and partner organisations should therefore view and respond to challenges brought under this procedure in a positive manner.

Professional Courage – Professional Curiosity – Professional Challenge



Learning and Development Training Evaluation Form 2025

South Gloucestershire CHILDREN'S PARTNERSHIP