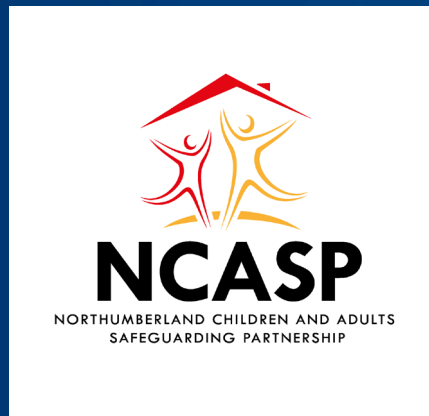




Northumberland
County Council

Safeguarding Children Drop In



www.northumberland.gov.uk

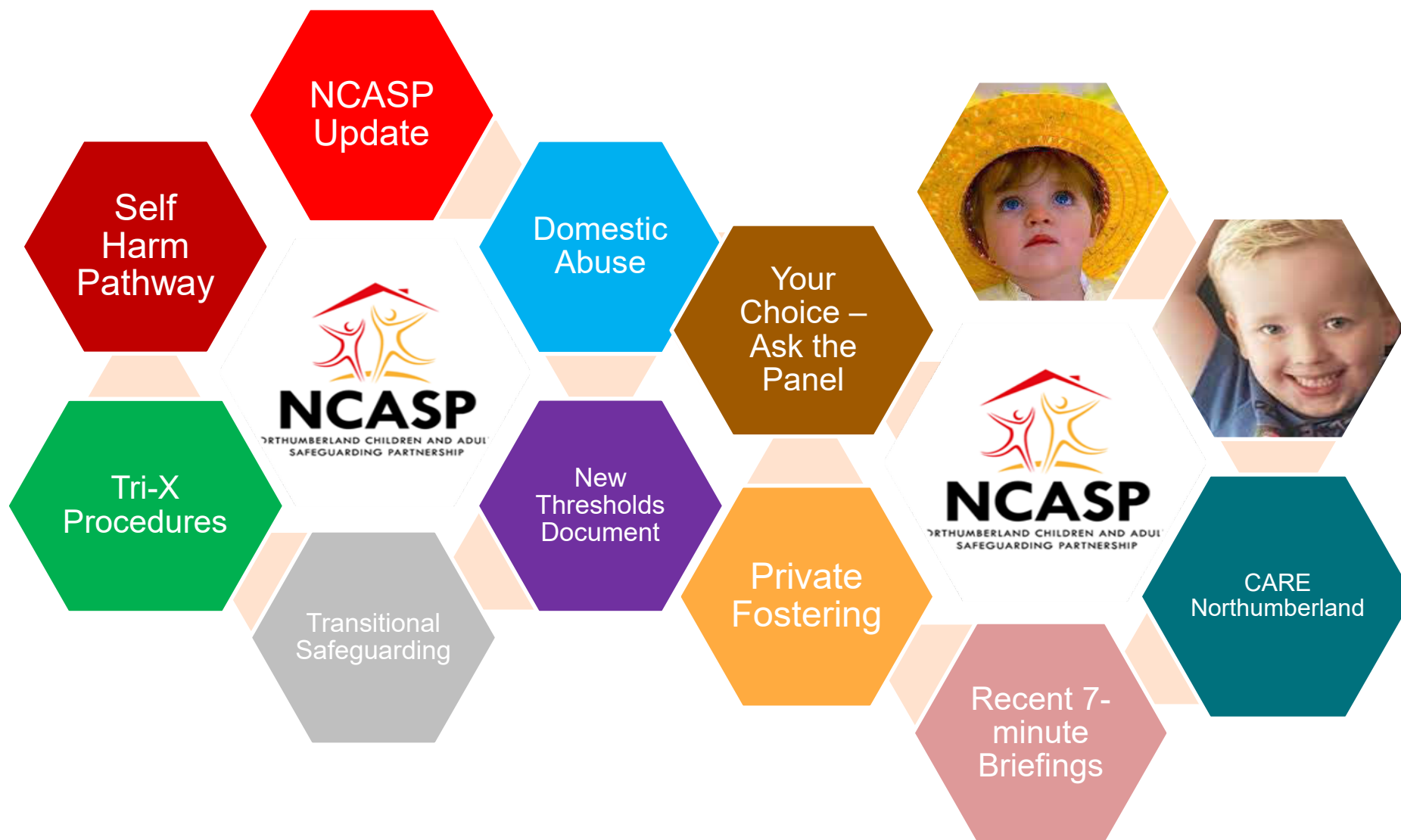
Quick Acronym Quiz

1	• NCASP
2	• CPVA
3	• MARAC
4	• MAPPA
5	• LADO
6	• SoS
7	• SHB
8	• MASH
9	• ICPC
10	• FII
11	• MSET
12	• MATAC



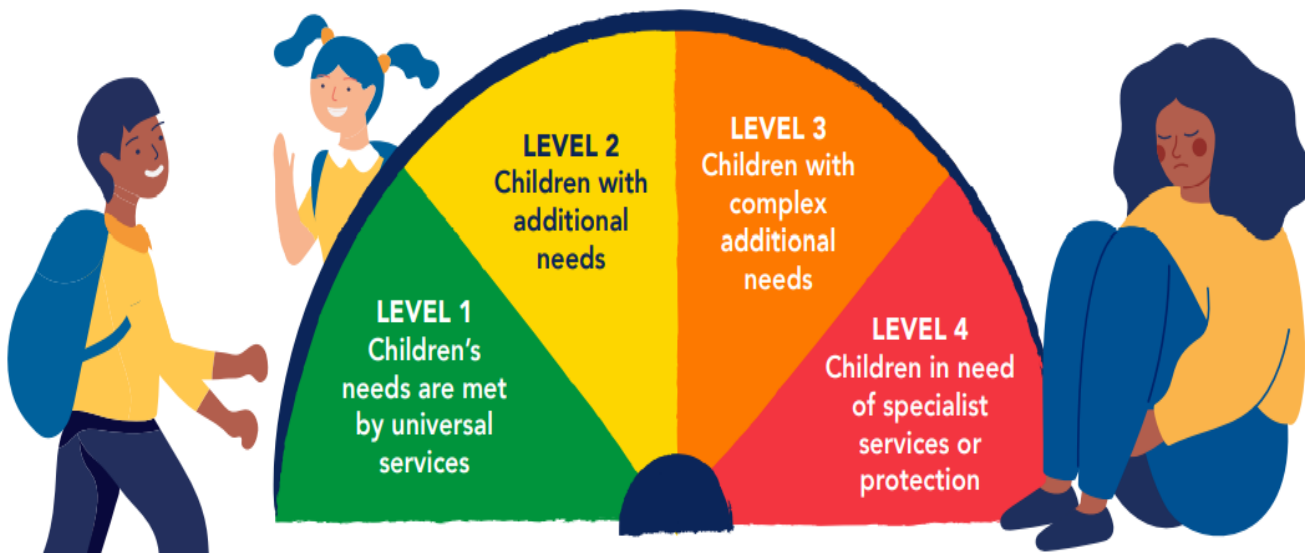
1	• Northumberland Children and Adult Safeguarding Partnership
2	• Child to Parent Violence and Abuse
3	• Multi Agency Risk Assessment Conference
4	• Multi Agency Public Protection Arrangements
5	• Local Authority Designated Officer
6	• Signs of Safety
7	• Sexually Harmful Behaviour
8	• Multi Agency Safeguarding Hub
9	• Initial Child Protection Conference
10	• Fabricated or Induced Illness
11	• Missing, Slavery, Exploitation and Trafficking
12	• Multi Agency Tasking and Coordination protocol

Let's Talk About Safeguarding Children....



New Thresholds Document

<https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Child-Families/Safeguarding/Threshold-document-FINAL-October-2022.pdf>



Seven Minute Briefings

Learning Review Briefings

- Fiona
- Aaron and Bobby
- Caitlin
- George
- Harry

Thematic Briefings

- Caring about Adversity, Resilience and Empowerment (CARE)
- Exploitation and Language
- Contextual Safeguarding

7. Key Learning

- Where there is any suspicion of bruising in an immobile baby action should be taken immediately, and a referral made to GSC.
- When a section 47 (child protection) investigation does not lead to an ICP being held, those agencies involved in the original strategy meeting should be consulted to ensure they are in agreement with the decision.
- Information should be shared across agencies so the wider family context can be considered.
- The child's voice should be reflected in all agencies' documentation about them, and included in wider assessments of risk.
- Strategy meetings should be held within timescales and all agencies should attend, particularly Police where a crime may have been committed.
- Good quality supervision should be in place to ensure the right cases receive safeguarding supervision, contain challenge where required, and cases are appropriately risk assessed.
- Where there are concerns and evidence of childhood neglect, this should be clearly identified in records using the word 'neglect' and discussed accordingly at relevant meetings.

6. Good Practice

- Acute Hospital Safeguarding Team responded to an anonymous tip off regarding concerns that George had bruising which had not been initially picked up. As a result, bruises were then identified. Mother was overheard saying to father on 'Footline' that the bruises were there from birth (birthmarks) but father said they were there only the day before. This conflicting information provided evidence to support the non-accidental injury explanation for the bruises.
- GP practice ensured appropriate coding was placed on father's file after a MAAR (domestic abuse) case in 2018 as well as sharing information regarding father as part of a 'Sharing Information Regarding Safeguarding' (SIRS) request – a process in place to ensure appropriate information is shared regarding a father when his partner is pregnant.

5. Themes

- Bruising in immobile baby
- Parenting ability (both) and 'The Myth of Invisible Men'
- Decision making, risk assessment and management oversight
- Multi-agency working
- Neglect
- Information sharing
- Voice of the child
- Provision of professional supervision for safeguarding
- Child in Need versus Child Protection?

1. George – Background

- George and his sibling aged 2 1/2 had been subject of child in need plans since July 2020. Signs of neglect.
- April 2023, George presented at Paediatric Emergency Department with severe oral thrush so serious he was admitted to hospital. He was observed to have four potential bruises on his face, two of which (one either side of his head) were later determined to be non-accidental injuries. First Skeletal survey identified no initial remarkable findings.
- Second skeletal survey was undertaken two weeks after the first as per local protocol. Survey indicated George had a healing fracture to his left tibia and four healing fractures to his ribs. Assessment of these injuries by clinical experts was that they were indicative of non-accidental injury.

2. Family context

- Family known to multiple agencies over an extended period of time.
- Mother – concerns around mental health and excessive alcohol misuse. Diagnosis of emotionally unstable personality disorder. History of sexual abuse as a child and spent some time in care.
- Father – known to adult social care relating to domestic abuse – including incidents as an alleged victim of financial abuse (perpetrator his mother) and a threat of violence by him (with a knife) to a younger sibling. He also had mental health issues, autism and ADHD.
- George's older sibling had previously been noted during a hospital appointment to have had a higher than usual number of bruises that were mostly explained but indicated inadequate supervision; there remained three bruises which were unexplained.

3. Areas of concern

- Bruising notified by hospital staff but not acted upon immediately until anonymous call received by social worker alleging bruising to George and sibling.
- Similar patterns of previous concerns around sibling that did not lead to a pre-birth plan for George.
- Concerns around sibling led to a delayed 'on-line' strategy meeting that police were not able to gain access to, in order to share information with the children's social worker.
- S47 enquiries did not lead to an initial Child Protection Conference (CPC) or CP plan.
- Newly qualified staff had limited supervision and staff changes led to a lack of continuity and oversight.
- Accumulation of concerns relating to the parents' historical and recent behaviours were not collated or analysed sufficiently in the care planning.

4. Areas of concern

- Potential gap in the Mental Health Trust's clinical and safeguarding supervision, ongoing monitoring and safeguarding review of mother.
- Categorising a case as a Child in Need has implications for how it is viewed and managed by other agencies.
- Vulnerabilities of the father were not necessarily shared with the children's social worker.
- Sibling's nursery raised concerns over sibling's behaviour and presentations, social work visits to speak to child were unsuccessful.
- Provision of professional supervision to staff working with the family appears to have been inconsistent, with gaps evident across some of the agencies.

1 What is it?

Contextual safeguarding seeks to identify and respond to harm and abuse posed to young people outside their home, either from adults or other young people.

2 Why is it matters

Traditional approaches to protecting children/young people from harm have focused on the risk of violence and abuse from inside the home, and don't always address the time that children/young people spend outside the home.

3 Why it matters

As children move from early childhood and into adolescence they spend increasing amounts of time socialising independently of their families. The nature of young people's relationships, that they form in these settings, inform the extent to which they encounter protection or abuse.

7 What should we do?

Identify the ways in which young people can change the social conditions where abuse has occurred, and encourage self-responsibility for making these changes. Engage with individuals and sectors who have a bearing on social contexts, i.e. shopkeepers, local policing, community leaders, to make environments safer.

6 What should we do?

A Contextual Safeguarding approach aims to disrupt harmful extra-familial contexts rather than move young people away from them. The approach seeks to identify the ways in which professionals, adults and young people can change the social conditions of environments in which abuse has occurred.

4 Peer relationships

Research tells us that peer relationships are increasingly influential during adolescence. If a young person forms friendships in contexts characterised by violence and/or harmful attitudes these relationships will be anti-social and unsafe.

5 What are the risks?

There are a wide range of potential risks where the prime cause of harm is outside of the family. This list isn't exhaustive but includes: peer on peer abuse; exploitation and online abuse; missing episodes; gang involvement; radicalisation; trafficking and modern slavery.

Northumbria Safeguarding Children Partnership
<https://www.northumbria.gov.uk/Children/Safeguarding.aspx>
 Acknowledgement to Wirral Safeguarding Children Partnership

7. Key Learning

- Descriptions and language should accurately reflect the child's voice, not subjective personal views and opinions.
- Where a parent/carer has a learning disability/difficulty, the appropriate assessment should be undertaken, with the child's well-being always being the focus.
- Where a child's behaviour or presentation changes professionals should seek the reasons for this from the child, not focus on the child as the problem.
- Understand the burden of secrecy on the child to protect themselves and the family.
- When a child may have had sexual intercourse, speak to them alone, and if under 13yrs refer to social care.
- Where an agency has requested a strategy meeting and the team manager declines this, the rationale should be clearly documented and shared to enable further discussion if required.
- Longer term cases, especially those of chronic neglect, should be considered for independent review by a senior manager.
- Significant adults / family members in a child's life should be fully assessed and incorporated into safety plans. Information should be shared across agencies and constantly reviewed to ensure all relevant information is shared to protect the child.
- Where it is known a crime may have been committed against a child, the police should be informed.

6. Good Practice

- Caitlin appeared safe and supported in school, they listened to her, ensuring her voice was heard, acted in her best interests, the Education Welfare Officer undertook home visits.
- The paediatrician identified potential risk after disclosure of continued contact with mother's partner which Caitlin has been keeping 'secret', and made phone call to social worker followed up by referral.
- Families first supported with work around keeping safe, particularly around social media.

5. Themes

- Information sharing, little evidence of early, effective sharing across agencies, i.e. adults of risk in child's life.
- Gaps in multi-agency working and lack of prompt, effective strategy meetings to assess and mitigate risk.
- Frequent change of social workers in long term chronic neglect case, that may have benefited from independent manager review.
- Use of language to reflect risk.

1. CAITLIN – Background

- Caitlin was known to agencies throughout her life and was subject of a child protection plan in July 2015. Following concerns around mother's parenting capacity and physical abuse.
- Her hygiene and appearance deteriorated, she disclosed she had been hit by mother and mother's partner, and that she was keeping visits to the partner secret, contrary to social care plans. Mother reported her pregnant at 12yrs, although both grew negative.
- In July 2019 Caitlin began to go missing from home and refused to return.
- Caitlin was absent from school, and was found at home with her mother under the influence of drugs, with drugs on the table.
- Caitlin experienced bed wetting, soiling, head lice, poor hygiene and was self-harming.

2. Family context

- Only Caitlin, the youngest of 3 siblings, remained in mother's care despite inconsistent parenting and frequent concerns.
- Mother missed substances, had possible learning difficulties and prioritised her partner over Caitlin's care.
- Birth father had a history of domestic violence and abuse, and was deceased.
- Mother partners posed various risk including sex offending, domestic abuse and substance misuse.
- Maternal Grandmother was a protective factor.

3. Areas of concern

- Allegations of physical abuse were recorded by agencies as 'over chastisement' – not recognizing abuse and focusing on child's behaviour.
- A single agency assessment was undertaken which is not normal practice.
- It's unclear what information was sought from police about adults in Caitlin's life, to assess risk and inform decision making.
- Mother's undiagnosed learning difficulties/disabilities.
- Professionals understanding around mother's 'capacity' under Mental Capacity Act, versus 'capacity' to protect Caitlin.
- Frequent change of social workers during assessments.
- Child's behaviour and physical appearance deteriorated, the reasons behind this were not considered.

4. Further areas of concern

- There is no evidence a possible pregnancy was considered as a safeguarding issue or that Caitlin may have been the victim of a crime. Caitlin not spoken to about by GP and referral not made to social care.
- Information around pregnancy and supply of drugs to child was not shared with police.
- Strategy meeting was requested and declined by social care team manager and challenged by school nurse without response.
- Mother blamed child for appearance and behaviour.
- Mother hid ongoing contact with risky partner from services.

Arthur and Star – National Review



Arthur Labinjo-Hughes died age 6 in June 2020.

His father and father's female partner were convicted of manslaughter and murder respectively.

A total of 130 bruises were found on Arthur's body at the time of his death.

Blood tests indicated very high levels of sodium, suggesting the possibility of salt poisoning, CCTV footage showed that Arthur had been forced to stand to attention alone in the hallway of the house for most of the day, without water.

He was made to sleep downstairs on a hard floor without a mattress, with no contact from family members or friends, and out of the sight of children's social care, school, and other public services.

Common Themes

Covid lockdown made both children even more invisible

Co-habiting partners significantly increased risk

Professionals had very limited knowledge of what life was like for the child

Family members were not listened to when they reported concerns. They were seen as malicious

Failures in ensuring multi-agency assessment and following multi-agency procedures and processes



Star Hobson died age 16 months in September 2020. Her mother and mother's female partner were convicted of causing or allowing her death.

CCTV footage, when Star was in the sole care of mother's partner, showed Star being physically assaulted with 20 separate blows to the head and body recorded over a period of two hours.

Star had many bruises on legs, arms and face.

The professional understanding of and response to domestic abuse between mother and her partner was inadequate.

Transitional Safeguarding - case for change

- Adolescents have distinct safeguarding needs and harms and routes to protection - often 'contextual' / extra-familial
- Harm and its effects do not abruptly end at 18; support may do
- Transition to adulthood is a particularly challenging and vulnerable time
- Young people may need care and support without having 'Care & Support needs'
- Need to consider promoting resilience and their changing developmental needs
- Need a reimagined safeguarding system which is contextual, transitional and relational.
- It is not a prescribed model - Transition is a journey not an event.

“Sometimes you just have to do something because it’s the right thing to do”

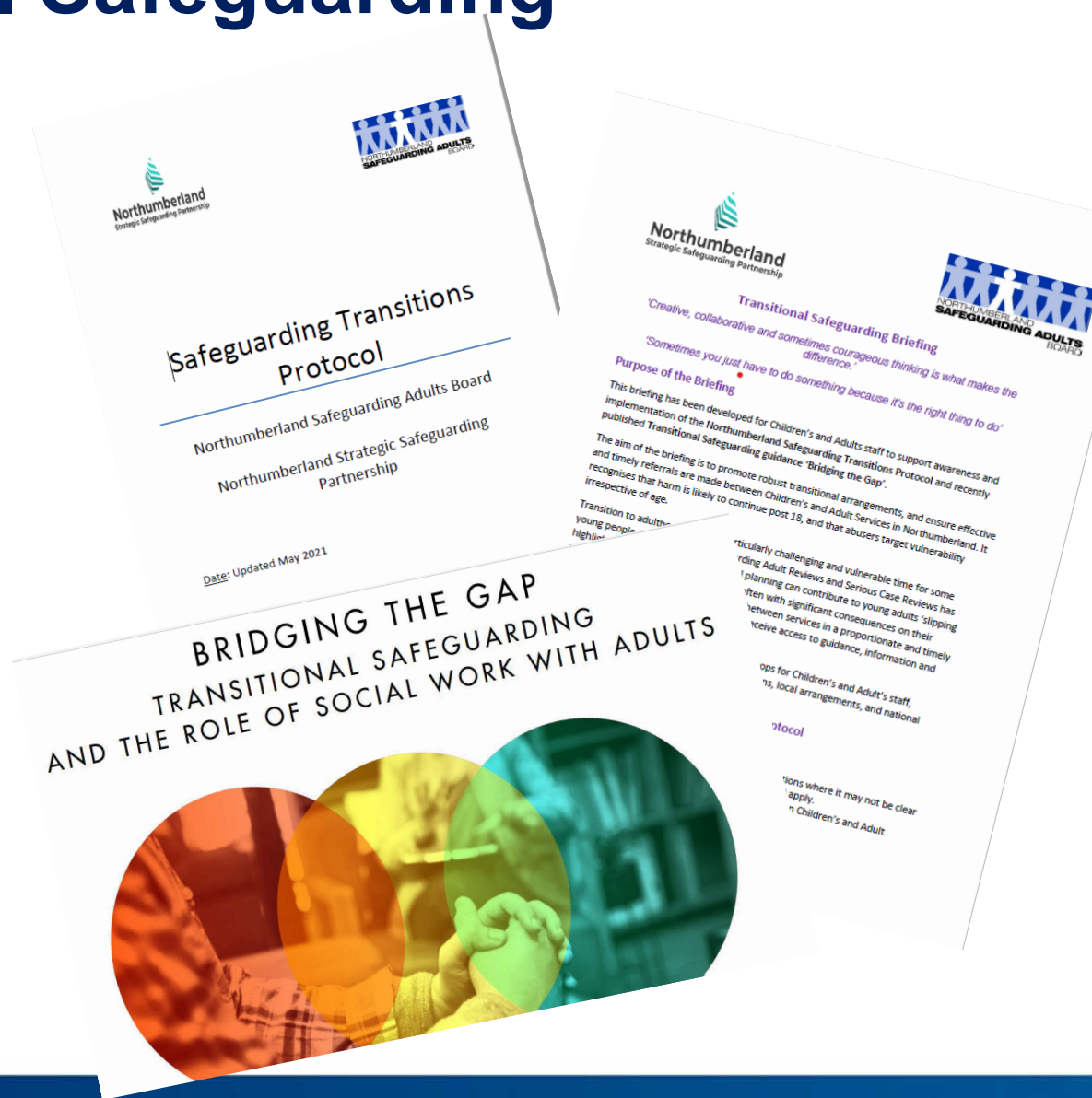
Fran Leddra, Chief Social Worker for Adults

Real experiences.....

[Transitional Safeguarding \(Part 2\) - Case study reflections - YouTube](#)

Transitional Safeguarding

- Safeguarding Transitions Protocol
- Bridging the Gap national guidance
- Briefing for ASC/CSC staff
- Transitional Safeguarding case audit



The Local Context

Learning

- Local Learning reviews / case examples – Bobby, Aaron, AB, Harry
- Regional work/events
- Transitions audits
- 7 minute briefing
- Joint staff briefings
- Joint Transitional Safeguarding workshops

Joint Training and Development

- Vulnerability not Age
- Child to Parent Violence and Abuse
- MCA/DoLS training for CSC staff
- Joint training framework – approach to trauma/ACE's – C.A.R.E. Northumberland

Practice

- Joint planning & identification of support – DoLS/LPS
- Joint Transitional Safeguarding Protocol
- Transitions policy/panels
- Collaborative approaches across Teams

Strategic Commitment

- Priority for Children and Adults Safeguarding Partnerships
- Joint (All-Age) Strategic Exploitation sub group

Next Steps

- Roles and responsibilities briefing
- Embedding Safeguarding Transitions Protocol
- Multi-agency Transitional Safeguarding workshops

Embedding good safeguarding transitions

- Person centred and strengths based
- Start transition as early as possible/clear timescales
- All assessments and plans up to date
- Transition planning takes into account each young person's capabilities
- Point of transfer should not be based on a rigid age threshold, and time of relative stability for young person
- Joint visits with workers with a focus on handover
- Do not use non-engagement as a reason to close cases
- Making Safeguarding Personal – preparing young person and involving in planning and decision making

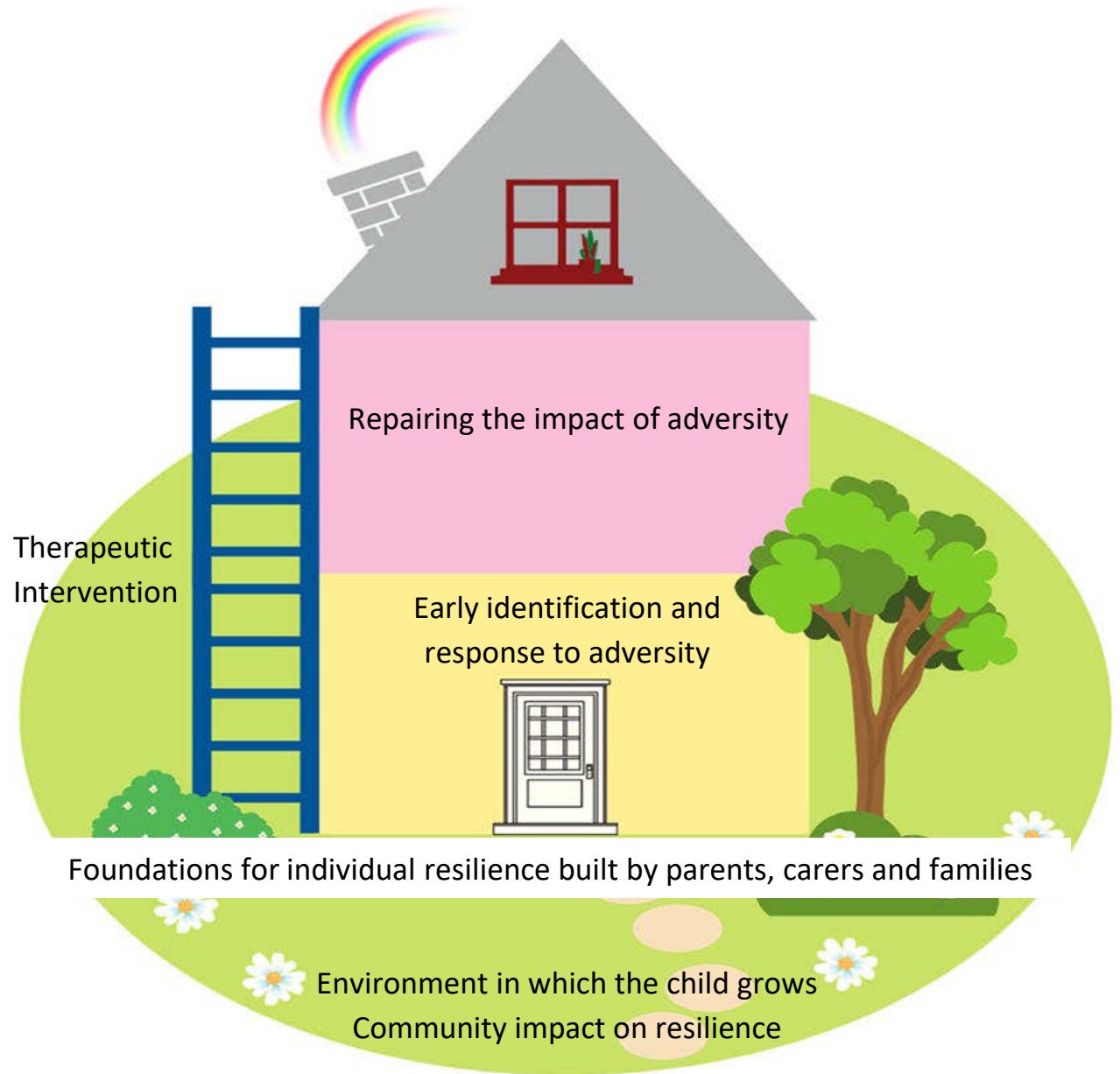




Procedure for the Management of Self Harm and or Suicidal Behaviour in Children & Young People



C.A.R.E.
NORTHUMBERLAND
Caring about Adversity, Resilience and Empowerment



CARE 7 minute briefing

C.A.R.E Northumberland -
YouTube

NCASP Board Update

Northumberland Children and Adults Safeguarding Partnership



- New Joint Arrangements
- Representation
- Sub Groups
- Learning from Reviews

Priorities:

- Transitional Safeguarding
- Neglect including Self-neglect
- Mental Health
- Safeguarding under 1s

‘It is our vision to work together and provide added value across the safeguarding system, to improve practice and outcomes, and safeguard and promote the welfare of children, young people, adults and their families in our community.’

Private Fostering

A child is privately fostered if they are:

- up to 16 yrs (or 18 if disabled) *AND*
- cared for and accommodated by someone who is **not a close family member** for longer than **28 days**.

The definition of 'close family member' includes:

- Parent or someone with parental responsibility
- Sibling/aunt/uncle/grandparent/step-parent

The Children Act 1989 makes it a statutory duty for Children's Social Care to be informed of any private fostering arrangement. There are clear legal requirements for CSC to assess and monitor the arrangement

Private Fostering

- What legitimate reasons might there be for parents to make private fostering arrangements?
- In what circumstances would private fostering be worrying?
- What do we need to consider when checking out / assessing the arrangements?



Further Information

- **Safeguarding Children Procedures:**

<https://www.proceduresonline.com/nesubregion/>

- **Safeguarding Children website:**

<https://www.northumberland.gov.uk/Children/Safeguarding.aspx>

- **Northumberland Safeguarding Children and Adults Partnership**

Email nssp@northumberland.gov.uk

Website <https://www.northumberland.gov.uk/Care/Support/Northumberland-Children-and-Adults-Safeguarding-Pa.aspx>

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