SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEEE

Date of Meeting	Thursday 15th November 2018
Report Subject	Safeguarding Adults and Children
Portfolio Holder	Cabinet Member for Social Services.
Report Author	Chief Officer Social Services
Type of Report	**Strategic**

EXECUTIVE SUMMARY

To provide members with information in relation to the Joint Adults and Children's Safeguarding provision within the county boundaries

In line with the Council's strategy for developing a systematic Performance Management Framework, Social Services routinely collate safeguarding activity for all aspects of safeguarding. This report is to inform Members of key statistical and performance related information about children and adults at risk for whom the Authority has significant safeguarding responsibilities.

This report is also to highlight the variety of work covered by the Safeguarding Unit and the activity it undertakes

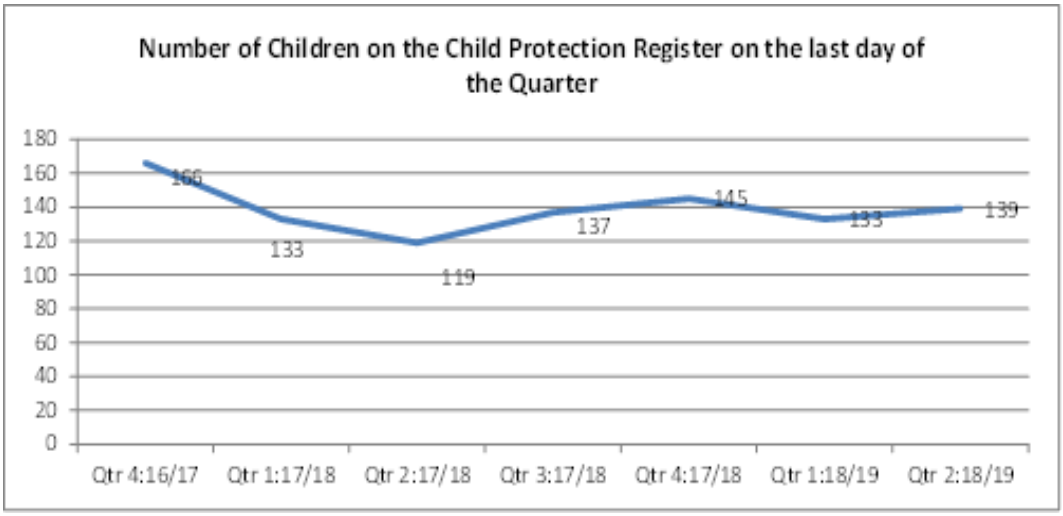
This report will also summarise some key learning from Child and Adult Practice reviews and Domestic Homicide Reviews

RECOMMENDATIONS	
1	That members accept this report as relevant information in relation to Flintshire Safeguarding for the period 1st April 2017 to 31st March 2018
2	That members take due regard to the variety of activity across the

	Safeguarding Unit and the continuing development and improvement in service provision.

REPORT DETAILS

1.00	BACKGROUND
1.01	The Flintshire Safeguarding Unit has been an single unified team since early 2016. The Safeguarding Unit Service Manager has been in post for just over 2 years and reports directly to the Senior Manager for Safeguarding and Commissioning. The team currently comprises 20 people and is based in County Offices Flint. They have close working relationships with Children and Adult Social Care and key partner agencies.
1.02	The Safeguarding Unit oversees all aspects of work related to their core responsibilities which are: • Child Protection (CP) • Adult Safeguarding • Adults at Risk • Deprivation of Liberty Safeguards (DOLS) • Looked After Children (LAC)
1.03	**Children's Safeguarding and the Child Protection Register** The purpose of the Child Protection Register (CPR) is to keep a confidential list of all children in Flintshire who have been identified as being at risk of significant harm in accordance with the categories of abuse within the All Wales Child Protection Procedures (AWCPP) 2008. The Safeguarding Unit are responsible for maintaining the CPR, providing information to relevant partner agencies about children on the register and ensuring that Child Protection plans are formally reviewed in accordance with the AWCPP.
1.04	**Number on the Register** Numbers on the register fluctuate as cases progress through the system. If risk reduces, children may be removed from the register and supported through more informal means. If risk increases, cases can progress into court proceedings and children can be taken into care. The Safeguarding Unit have no control over the number of referrals into First Contact nor do they have influence over which cases come to conference. At the end of March 2017 there were **166 children** on the register. By the end of October 2017 there were **138 Flintshire children** on the register with 17 temporary registrations, totalling 155 children. At the end of March 2018 there were **145 children** on the register. By the end of September 2018 there were **139 Flintshire children** on the register

	with 35 temporary registrations totalling 174 children. As of November 2nd there were **159** children on the register, comprising 134 Flintshire children, 25 temporary registrations. 
1.05	**Categories of Risk** Currently the highest category is emotional abuse as a single category (57 children). The next highest is Physical and Emotional abuse (34 children). This is the same as last year with Neglect being the third highest category. The trend unfortunately continues to be linked with high levels of reported Domestic Abuse, usually linked to alcohol and/or drug misuse.
1.06	**Length of time on the register** Children on the register are reviewed in line with AWCPP guidelines. Initially at 3 months and thereafter within 6 months. Children reaching their 3rd review are automatically reviewed under the County and Public Law Outline and are subject to a Legal Advice Meeting (LAM) to identify whether the case should be moving into court proceedings. Children's Safeguarding Managers regularly review cases that have been on the register for 12 months or more. The findings are reported to Senior Managers and discussed within Regional Safeguarding Delivery Groups. On 30th September there were 16 Flintshire children from 8 families who had been on the register for over 12 months. The longest being 22 months There are processes in place with Children's Services Service Managers to ensure such cases are reviewed within Legal Advice Meetings and Senior Managers meetings to ensure there is no drift. A recent audit of cases which had been on the register over 12 months in both Wrexham and Flintshire reported that the themes of those cases were

	very similar; compliance with CP plans, alcohol/drug misuse, domestic abuse relationships, indicating a motivation to change, stabilisation and reduction in risk, lapse and relapse. In such cases, there is not enough evidence to support removal from the register but thresholds are not met to move into court proceedings.
1.07	**Number of Child Protection Case Conferences held** The breakdown for the number of case conferences held is given below. Up to 8 conference a week are chaired and minuted by the Safeguarding Unit. Initial case conferences are convened within 15 working days of the strategy decision to come to conference and reviews are held as stated in 1.06. In Flintshire, from April 2017 – March 2018, 91% of initial child protection conference and 98% of review conferences were carried out within statutory timescales. From 1st April 2018 to 30th September 2018 82% of initials and 100% of reviews were held in timescales. Numbers of initial conferences have dropped slightly this year but there has been a corresponding decrease in the numbers of Section 47 investigations (Children Act 2004) carried out by First Contact. This may or may not be attributable to the new Early Help Hub. Data is still being collated about this. Any conferences that have to go outside timescales are agreed with the Service Manager for Social Care and Safeguarding. In the interim, Children's Social Services ensure immediate safeguarding issues are managed with relevant partner agencies.
1.08	**Looked After Children** Despite increases in the number of children on the CPR, the number of Looked After Children has remained relatively steady. At the end of October 2018 there were 239 children being looked after by the Local Authority. Between 1st April 2016 and 31st March 2017, 59 children started to be looked after. Between 1st April and 31st March 2018, 62 children started to be looked after. 66 have left care and 75 have moved placement. Children can leave care for a number of reasons, either going home to their families, becoming adopted or reaching 18 years of age where they no longer need to be reviewed under looked after procedures. Children can receive support and services up to the age of 19 from transition services. Young people can also be supported through Pathway Plans up until they are 24 years old should they need this input. There are 3 Independent Reviewing Officers (IROs), within the Safeguarding Unit who review Care Plans and ensure placements are appropriately supporting the children.

	Flintshire Children are in the main located with Flintshire Foster Carers or at home under Placement with Parents regulations. However, IROs do have cases as far as South Coast of England, North of England and Ireland and they are expected to travel to the placement address to hold their reviews.
1.09	**Deprivation of Liberty Safeguards (DOLS)** The Safeguarding Unit has 2 fully qualified Best Interest Assessors (BIAs) who are responsible for undertaking Best Interest Assessments for individuals who meet criteria in accordance with the March 2014 Supreme Court ruling otherwise referred to as the Cheshire West case. At that time the Supreme Court made a ruling which greatly widened the scope of Deprivation of Liberty Safeguards which meant that anyone in a care home is being deprived of their liberty if they: • Lack mental capacity to agree to live in the care home and • Are under continuous supervision and control and • Would be prevented from leaving the care home if they were to try to do so Deprivations of Liberty in Flintshire care homes are assessed by a BIA with a mental health and mental capacity assessment carried out by a doctor who is qualified under Section 12 of the Mental Health Act 1983. In 2013-14, 13 applications were received; in 2014-15, 255 applications were received. Between 1st April 2016 – 31st March 2017, 277 applications were received. Between 1st April 2017 – 31st March 2018, 397 applications were received with another 248 being received by Flintshire from 1st April this year to end September.
1.10	The DOLS team, under the management of a new Senior Practitioner has developed systems and processes to improve the management of this area of the team and constantly review the applications to ensure those of high priority are dealt with quickly. The difficulties encountered are reflected both locally, regionally and nationally. From 1st April 2017 – 31st March 2018 the DOLS team have completed 249 applications. 171 applications were completed between 1st April 2018 and 30 September 2018.
1.11	There is currently a review of the DOLS process nationally and Flintshire, along with regional colleagues await changes to the system which may reduce demand and therefore make better use of limited resources.
1.12	**Adult Safeguarding and Adults at Risk**

	The Adult Safeguarding team and Adult at Risk team has undergone a substantial restructure of both staff and process over the past 12 months. Referrals into adult safeguarding have been increasing year on year. The Social Services and Wellbeing (Wales) Act 2014 (SSWBA) expects the Local Authority to undertake s126 enquiries within 7 working days of receipt of the adult safeguarding report. This effectively means that a decision has to be made within that timescale as to next steps. The Single Point of Access (SPOA) team has also undergone substantial restructure and Safeguarding works closely with this team to ensure a co-ordinated response to all referrals. From 1st April 2017 – 31st March 2018, 84% of safeguarding decisions under s126 SSWBA (Wales) were made within 7 workings days. This was achieved whilst the team were undergoing substantial change and restructure. The team also lost a post in December 2017. From 1st April 2018 – 30th September 2018, 94% of decisions were made within 7 working days. This is a reflection of changes in processes and systems and also, a robust working relationship with SPOA. From 1st April 2017 – 31st March 2018 528 referrals were received about 403 people with an additional 305 referrals being received for 261 people from 1st April 2018 to 30th September 2018. The Adult Safeguarding Team have convened 171 strategy meetings between 1st April 2017 and 31st March 2018 with an additional 85 being held in the following 6 months. The Adult Safeguarding Team undertake internal audits on a regular basis to identify areas for development and ensure consistency of approach. Adult Safeguarding have also recently undergone an Internal Audit which has been conducted in conformance with the Public Sector Internal Audit Standards. The Audit was commissioned through the Corporate Safeguarding Board and covered: • The front end of safeguarding process including triage and screening of all referrals • Processes in place for managing all safeguarding referrals in accordance with the SSWBA (Wales) 2014 • The effectiveness of strategy meetings • Statistical data within the council to track trends The Audit is due to be published at the end of this month but the Audit Opinion is Amber Green which indicates that key controls are in place and operating effectively but some fine tuning is required. There were 4 agreed actions (1 amber and 3 green) which will be monitored. Some of the agreed actions were around reviews and the final stages of safeguarding cases.

	This is the next priority of the Safeguarding Unit having spent the majority of the past year ensuring the front end of the safeguarding referral process was robust. Another action is to ensure partner agencies and social work colleagues were fully aware of safeguarding processes so that they could contribute effectively. This is a priority of the Corporate Safeguarding Panel and also the Regional Safeguarding Board. A number of training sessions have taken place over the last year to ensure the message about Adult Safeguarding is delivered effectively and consistently. The Regional Safeguarding Board have recently relaunched the Adult Safeguarding Report form together with Top Ten tips for completing a referral form. The Corporate Safeguarding Panel have circulated a short guide detailing how to raise concerns about adults or children. This was drafted by the Safeguarding Unit and is currently being printed by the Regional Safeguarding Board for wide circulation.
1.13	**Learning from Child Practice Review (CPR), Adult Practice Reviews (APR) and Domestic Homicide Reviews (DHR)** In accordance with the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015 (which came into force 6 April 2016), Safeguarding Boards have a statutory responsibility to undertake multi-agency practice reviews in circumstances of a significant incident where abuse or neglect of an adult at risk is known or suspected and the adult or child has died, sustained potentially life threatening injury or serious and permanent impairment of health or development. Practice guidance for completing practice reviews has been issued under section 145 Social Services and Well-Being (Wales) Act 2014. The purpose of practice reviews is to learn lessons, to inform and improve practice. The outcome of a review is intended to generate professional and organisational learning and promote improvement in future inter agency protection guidance. Practice reviews do not seek to apportion blame. There are two types of review: • Concise Practice Reviews – when the person was not referred to services for protection within 6 months of the incident or death • Extended Practice Reviews – when the person was referred to services in the 6 months prior to the incident or death

	If the criteria for the above is not met, a decision can be made to hold a Multi-Agency Professional Forum (MAPF) which is a learning event that sits outside the Regional Safeguarding Board APR/CPR review sub group. MAPF utilise case information, findings from audits, inspections and reviews to develop and disseminate learning to improve local knowledge and practice and also inform the Safeguarding Board's future audit and training priorities. Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. Community Safety Partnerships are required to undertake them. The Community Safety Partnership then monitors the action plan.
1.14	**Flintshire APRs and CPRs** When cases come to the attention of safeguarding, consideration is always given to whether a case should be recommended for APR or MAPF. This consideration is also part of the safeguarding audit tool. Adult Locality teams can also refer cases to the APR subgroup as can any agency. Consideration for a CPR is usually determined within a PRUDIC (Procedural Response for Unexplained Death in Children) meeting however, again any agency can refer to the CPR subgroup. Currently in Flintshire, there is one CPR report is due to be published and the action plan is awaiting ratification by the Regional Safeguarding Board. One APR report was finalised recently and is awaiting publication. The action plan is already being reviewed within partner agencies and Social Services. The work on the second APR is due to commence shortly. The CPR is about the Flintshire mother who murdered her baby in 2016 and was sentenced earlier this year. A Learning event has already been held with key practitioners and agencies. The APR is about an adult without capacity who was dependent on her son and carers. She was bedbound. There was no evidence to suggest her death was attributable to a direct result of abuse or harm. Some of the issues were linked to professionals having problems dealing with her challenging and verbally aggressive son/carer. The North Wales Region has been adhering to the SSWBA by actively considering cases that would fit the criteria for APR/CPR. This means that North Wales has the correct number of active cases, particularly with APRs. This has a resource impact on all agencies and there has been an issue with delays in commencing reviews due to scarcity of trained reviewers./ The Board is addressing this issue currently and training is underway to identify new reviewers.

1.15	**Learning from CPRs and APRs** • When relevant CPRs are published nationally, Practice Directives are drafted by Flintshire's Children's Services Team Managers with summaries of the key issues and these are shared with all teams • The Regional Safeguarding Board send out weekly bulletins highlighting published CPRs and APRs regionally. • Learning events are held following CPRs and APRs where practitioners meet to discuss key themes and lessons from the investigations. • Action Plans emanating from CPRs and APRs are monitored locally and regionally through the Safeguarding Board and through the Flintshire & Wrexham Children's Delivery Group and the Flintshire & Wrexham Adult Delivery Group, subgroups of the Children's and Adults Regional Boards • Regionally every Local Authority has had a number of CPRs, APRs and MAPFs over the past 3 years. To support the sharing of learning across North Wales a learning event is being held on November 9th collating all the learning from the regional cases. • Specific recommendations from other Local Authority CPRs/APRs can come from other agencies for action within Social Services. One example of this was an Extended Child Practice Review in a neighbouring Local Authority where an asthmatic child had died. In the CPR, it was determined that the child's asthma medication was not being collected from the GP surgery and therefore not being administered. As a result of this, a request was made that an additional question was added to the GP report for child protection case conference purposes. Is the child on any regular medication? If so have repeat prescriptions been regularly requested and collected? • The request came from Betsi Cadwaladr University Health Board's Named Doctor for Safeguarding to Heads of Service and was then implemented within each Local Authority. One of the issues from such recommendations is reliance on another partner organisation to implement the change. • All CPR and APR Final Reports are published on the Welsh Government website and North Wales APR and CPR Reports are also published on the North Wales Safeguarding Board website.
1.16	**Domestic Homicide Review** The tragic death of a Flintshire woman in September 2014 necessitated the Flintshire Community Safety Partnership to undertake a Domestic Homicide Review (DHR). The purpose of a DHR is to examine the circumstances that led to the death, and review the contact that organisations had with the

	victim and offender, and identify lessons to be learnt. Marie (not her real name) was murdered by her boyfriend, identified in the report as P1, following a very brief relationship. He was convicted of her murder and sentenced to life imprisonment with a direction from the trial judge that he must serve at least seventeen and a half years in prison before he is considered for release. The Flintshire Domestic Homicide Review was published on the Flintshire County Council website in July 2018 and a link in the Appendix is attached with details of the summary.
1.17	**National Learning from Reviews** **Learning from Reviews: Analysis of emerging Themes from Child practice, Adult Practice and Domestic Homicide Reviews in Wales** *(Public Health Wales National Safeguarding Team)* 1 April 2017 – 31 March 2018 This document recently circulated highlights the findings from 12 published reviews in Wales which comprised 2 DHRs, 5 CPRs and 5 APRs. The DHR was undertaken in Flintshire. The Action Plan is being monitored by the Flintshire Community Safety Partnership. The main emerging themes that featured within the majority of cases were highlighted within the report. The most frequently occurring theme within all reviews, in both adult and child cases, was related to communication failures, information sharing processes and communication between agencies and families. Other themes were detailed as: • Professional knowledge and skills • Voice of the child • Policy issues and compliance • Disguised compliance • Assessment and analysis • Legislation and guidance
1.18	Social Services managers and staff are acutely aware that the key messages from National, Regional and Local APRs/CPRs are usually about lack of information sharing and poor communication between partner agencies. Flintshire Social Services are well informed about current themes and trends in outcomes of APRS/CPRs. Case file audits, supervision, legal advice meetings, multi-agency case management meetings, learning and training workshops, access to online research and case discussion are all tools to ensure outcomes from APRs/CPRs are at the forefront of the work that is undertaken in Flintshire to safeguard children, adults and families.

2.00	RESOURCE IMPLICATIONS
2.01	There are no financial implications arising from this report.

3.00	CONSULTATIONS REQUIRED / CARRIED OUT
3.01	N/A

4.00	RISK MANAGEMENT
4.01	N/A

5.00	APPENDICES
5.01	Top tips for making a Safeguarding referral
5.02	Reporting Safeguarding Concerns
5.03	Domestic Homicide Review

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS
6.01	**Contact Officer: Jayne Belton – Safeguarding Unit Service Manager** **Telephone: 01352 702600** **E-mail: Jayne.belton@flintshire.gov.uk**

7.00	GLOSSARY OF TERMS
7.01	**Looked After Child** Looked after children are children and young people who are in public care and looked after by the state. This includes those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks or respite care. The term is also used to describe 'accommodated' children and young people who are looked after on a voluntary basis at the request of, or by agreement with, their parents.
7.02	**All Wales Child Protection Procedures 2008** All Wales Child Protection Procedures, implemented on April 1st 2008, help safeguard children and promote their welfare. The All Wales Child Protection Procedures 2008 replace earlier jurisdiction.

	They address a wide range of safeguarding issues, including new mediums in which abuse can occur, such as the internet, and incorporate learning from research and practice from other parts of the world.
7.03	**Section 47 Investigation** Where information gathered during a Referral or an Assessment results in the social worker suspecting that the child is suffering or likely to suffer Significant Harm, a Strategy Discussion Meeting should be held to decide whether to initiate enquiries under Section 47 of the Children Act 1989. Strategy Discussions/Meetings should be held as soon as possible, bearing in mind the needs of the child. A Section 47 Enquiry will decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm.
7.04	**Section 126 Enquiry** Section 126 (2) of the SSWBA sets out that 'if a local authority has reasonable cause to suspect that a person within its area (whether or not ordinarily resident there) is an adult at risk, it must; a) Make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken (whether under the Act or otherwise) and if so, what, and by whom; and b) Decide whether any such action should be taken.'