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To: Cllr Carol Ellis (Chair)

Councillors: Mike Allport, Marion Bateman, Jean Davies, Andy Dunbobbin, Gladys Healey, Cindy Hinds, Kevin Hughes, Rita Johnson, Mike Lowe, Dave Mackie, Hilary McGuill, Ian Smith, Martin White and David Wisinger

9 November 2018

Dear Councillor

You are invited to attend a meeting of the Social & Health Care Overview & Scrutiny Committee which will be held at 3.00 pm on Thursday, 15th November, 2018 at Llys Raddington, Earl Street, Flint CH6 5ER to consider the following items

Please note Members are requested to arrive at Llys Raddington at 2.00 p.m to take part in a tour of the facilities prior to the meeting starting at 3.00 p.m.

Members are asked to note the venue for the meeting. Car parking is limited so attendees may need to park in the public pay and display car park at the Jade Jones Pavilion.

A G E N D A

1 APOLOGIES

Purpose: To receive any apologies.

2 DECLARATIONS OF INTEREST (INCLUDING WHIPPING DECLARATIONS)

Purpose: To receive any Declarations and advise Members accordingly.

3 MINUTES (Pages 3 - 10)

Purpose: To confirm as a correct record the minutes of the meeting held on 4 October 2018.

4 **PROGRESSION MODEL – LEARNING DISABILITIES** (Pages 11 - 20)

Report of Chief Officer (Social Services) - Cabinet Member for Social Services

Purpose: To receive a report on the Learning Disabilities Progression model.

5 **SAFEGUARDING – ADULTS & CHILDREN** (Pages 21 - 78)

Report of Chief Officer (Social Services) - Cabinet Member for Social Services

Purpose: To provide Members with statistical information in relation to Safeguarding & Adults & Children

6 **BRIGHT SPOTS** (Pages 79 - 170)

Report of Chief Officer (Social Services) - Cabinet Member for Social Services

Purpose: To consider the survey findings of looked after children

7 **ROTA VISITS**

Purpose: To receive a verbal report from Members of the Committee.

8 **FORWARD WORK PROGRAMME (SOCIAL & HEALTH CARE)** (Pages 171 - 176)

Report of Social and Health Care Overview & Scrutiny Facilitator

Purpose: To consider the Forward Work Programme of the Social & Health Care Overview & Scrutiny Committee

Yours sincerely

Robert Robins
Democratic Services Manager

SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE
4 OCTOBER 2018

Minutes of the meeting of the Social & Health Care Overview & Scrutiny Committee of Flintshire County Council held in the Delyn Committee Room, County Hall, Mold on Thursday, 4 October 2018

PRESENT: Councillor Carol Ellis (Chair)
Councillors: Marion Bateman, Jean Davies, Mike Lowe, Dave Mackie, Hilary McGuill, Martin White, Ian Smith and David Wisinger

SUBSTITUTIONS: Councillors Mike Reece (for Cindy Hinds) and Dave Hughes (for Ian Smith)

APOLOGIES: Councillor Rita Johnson

CONTRIBUTORS: Councillor Christine Jones, Cabinet Member for Social Services; Chief Officer (Social Services), Senior Manager - Safeguarding and Commissioning, Senior Manager Integrated Services Lead Adults/Early Years, and Service Manager, Disability, Progression and Recovery – Adult Services
(For minute no.22) Andrew Lloyd-Jones, General Manager, Double Click
(For minute no.23) Sarah Bartlett, Regional Project Manager, North Wales Social Care and Well-Being Improvement Collaborative

IN ATTENDANCE: Social & Health Care Overview & Scrutiny Facilitator and Democratic Services Officer

20. DECLARATIONS OF INTEREST

There were no declarations of interest.

21. MINUTES

(i) The minutes of the joint meeting with Education & Youth Overview & Scrutiny Committee held on 24 May 2018 were received.
(ii) The minutes of the meeting held on 14 June 2018 were received.

RESOLVED:

That the minutes of both meetings be approved as a correct record and signed by the Chair.

22. DOUBLE CLICK SOCIAL ENTERPRISE – PROGRESS REPORT

The Senior Manager Integrated Services Lead Adults/Early Years introduced the report to inform of the progress of Double Click since its commencement as a Social Firm. She invited the Service Manager, Disability, Progression and Recovery – Adult Services, to present the report.

The Service Manager, Disability, Progression and Recovery – Adult Services, provided background information and context and advised that Double Click had progressed greatly as a fully independent Social Enterprise, offering increased employment and training opportunities for all staff including people with mental health issues . She continued that as a result of moving to a social enterprise Double Click could employ people with a range of skills. Double Click had secured external lottery funding which had been used to purchase state of the art equipment that supported the development of the business.

The Service Manager reported on the main considerations, as detailed in the report, and referred to partnership working to enhance the experiences of trainees/volunteers, training, and grant funding. She introduced Andrew Lloyd-Jones, General Manager, Double Click, and invited him to give an overview of the services and the employment and training opportunities provided for all staff including people who had experienced or continued to experience mental health problems.

Mr Lloyd-Jones explained that there were three levels of learning at Double Click with the aim (at Level 3) of developing the trainee towards gaining an accreditation at Double Click in conjunction with a college or university. Although business orientated; Double Click was able to support its volunteers, trainees, and employees according to any additional needs. Mr. Lloyd-Jones continued that In addition to developing graphic/printing skills trainees were given the opportunity to acquire confidence by being involved in day to day administrative tasks and customer care, and supported in the management of cash flow and petty cash transactions. Mr Lloyd-Jones reported that Double Click currently had 22 trainees who were at different levels of development. The Learn Direct course was successful in developing trainees' skills in all aspects of graphic design and allowed individuals to learn at their own pace followed by 1:1 tuition and support from a member of staff qualified in graphic design. Each trainee had their own development programme and personal portfolio of work which was updated as the trainee progressed.

The Chair thanked Mr Lloyd-Jones for his presentation and invited Members to raise questions.

Councillor Dave Mackie referred to the statement of accounts for year ending 31 March 2017 which were appended to the report and congratulated Mr Lloyd-Jones and his team on the profit achieved by Double Click during its first year of operation and on meeting its target for sales. In response to a comment expressed by Councillor Mackie around the time taken to establish the business enterprise, the Service Manager explained that the setting up of the enterprise was a lengthy process due to the complexity of the legal and human resource matters which needed to be carefully addressed.

Councillor Hilary McGuill raised a concern around the financial contribution made by Flintshire County Council to Double-Click. The Chief Officer (Social Services) advised that there was no intention to reduce the financial contribution paid by the Authority and spoke of the great value that it

placed on the work of the service in supporting those with Mental Health issues. The Chief Officer (Social Services) went on to explain that the financial contribution was to deliver ongoing service user support as part of the Social Services provision, part of the ethos of Double Click and the services provided as a social enterprise in a nurturing and supportive environment. . Councillor Christine Jones commented on the recent visit of the Cabinet Secretary for Economy and Transport who recognised the great progress made by Double Click as a Social Enterprise which he described as a model of best practice for other sectors in the region.

In response to a further question from Councillor McGuill regarding the achievements of trainees on the training and development programme, the Service Manager suggested that Mr. Lloyd-Jones sends a list of the outcomes to the Committee for information. The Service Manager suggested that the Committee may wish to consider making a further visit to Double-Click. The invitation was accepted by the Committee.

The Chair thanked Officers for their attendance and answers to Members questions.

RESOLVED

(a) That the Committee recognises the positive progress achieved by Double Click Design and Print after 2 years as a Social Enterprise; and

(b) That the Committee continues to support and promotes Double Click as a Social Enterprise

23. NORTH WALES LEARNING DISABILITY STRATEGY

The Chief Officer (Social Services) introduced the report on the North Wales Learning Disability Strategy. He provided background information and context to explain the Strategy and advised that it was due to go to the Regional Partnership Board for approval in November 2018 after which it would go through the approval processes of the six local authorities and the health board.

The Chief Officer introduced Sarah Bartlett, Regional Project Manager, North Wales Social Care and Well-Being Improvement Collaborative, and invited her to present the report. The Regional Project Manager explained that to achieve the vision and provide services based on what mattered to people five work packages had been planned that would set out how things would change to achieve good lives for people with learning disabilities. The work packages take an asset-based approach to build on the skills, networks and community resources that people with learning disabilities already had. They will be co-produced with people with learning disabilities and their parents/carers. The key to achieving the vision will be to work with local communities to make sure people with learning disabilities are truly valued and included in their communities. Sarah Barlett reported on the five work packages outlined in the report.

The Chief Officer referred to the wide ranging consultations carried out on the Strategy which were detailed in the report and said questions and comments by the Committee were welcomed.

In acknowledging the comments made by Councillor Dave Mackie around the need for targets and actions to be made clear in the Strategy the Chief Officer drew attention to the measures on page 90 of the report as an example of the actions to be taken to implement the Strategy. The Senior manager Integrated Services Lead Adults/Early Years emphasised that this was an overall North Wales Strategy and work was ongoing in Flintshire with regard to implementing the strategy at a local level. She also referred to the need to address the requirements of a number of Acts within the sector.

Councillor Hilary McGuill referred to the number of children in the report with a severe or profound learning difficulty. She commented on the need for parents to have assurance that a Statement of Educational Need was in place throughout their child's education from primary school to higher education and college or university. She asked how well Social Services linked in with Education services. The Service Manager, Disability, Progression and Recovery – Adult Services advised that nurses and social workers have co-located teams which work very well. She added that with regard to educational need there is a transition team and a transition panel which meets with educational representatives on a monthly basis.

Councillor Andy Dunbobbin asked that reference be made to the Armed Forces in the Strategy. The Chief Officer agreed to take this forward.

Councillor Gladys Healey referred to training for GP's regarding learning disabilities and asked whether training was planned or already taking place. The Chief officer advised that there is some training taking place, however more consistency is required across the region. He added that people with learning disabilities are more likely to have poor physical health.

The Chair thanked Sarah Bartlett and officers for their attendance and detailed answers to Members questions.

RESOLVED:

That the Committee support the draft North Wales Learning Disability Strategy and recommend approval to Cabinet.

24. PROGRESS FOR PROVIDERS

The Chief Officer (Social Services) introduced a report to provide an update on 'Progress for Providers – Creating a Place Called Home … Delivering What Matters', and also informed the Committee of the recent success at the Social Care Wales Accolades Awards 2018. He invited the Senior Manager, Safeguarding and Commissioning to present a short video on Progress for Providers and to report on the main considerations as detailed in the report.

The Senior Manager, Safeguarding and Commissioning provided background information and advised that a recent key change in the care sector has been the introduction of the Social Services and Well-being (Wales) Act 2014 which required the sector to move away from commissioning task based services and move towards ensuring providers supported people to achieve their own personal outcomes and to promote well-being. She continued that this ethos was also reflected in the Older People's Commissioner for Wales Report of 2014 'A Place to Call Home? – A Review into the Quality of Life and Care of Older People Living in Care Homes in Wales' which was appended to the report. To take this concept forward the Authority extended an open invitation to all residential care homes in Flintshire and 16 of the 26 Nursing and Residential Care Homes committed to be part of the programme. The Senior Manager advised that these homes worked alongside the Authority's own in-house provider services, social work teams, Occupational Therapists, management teams etc. to implement person centred practice.

The Senior Manager explained that to recognise the progress that the care homes were achieving in implementing person centred care practices the Authority developed its own 'Progress for Providers' self-assessment toolkit. To show progression the Authority introduced 3 levels of accreditation which are validated by the Flintshire Contract and Commissioning Team in partnership with the Care Home Managers. In September 2018 the project was publicly recognised winning the Social Care Wales Accolades Awards for 'Excellent outcomes for people of all ages by investing in the learning and development of staff'. The project was also a finalist in the Association for Public Service Excellence (APSE) Awards – 'Celebrating outstanding

achievement and innovation within UK local government service delivery'. In conclusion the Senior Manager reported on the progress which had been made to date by residential care homes in Flintshire, as detailed in the report.

Councillor Hilary McGuill raised a concern around care homes which had not yet committed to the Programme. The Senior Manager explained that all the care comes were aware of the Programme and were engaged but at different stages of progress. She advised that the Contract Monitoring Team worked closely with care homes, providing guidance and support, to improve performance where necessary to enable them to achieve the desired outcomes and standards.

Councillor Gladys Healey commented on Flintshire residents who attended care homes in other areas, citing Wrexham and Cheshire as examples, and asked how the care homes were monitored. The Senior Manager explained that all authorities had a Contract Monitoring Team and the monitoring of practice was replicated across the region. In response to concerns expressed by Councillor Healey around poor practices the Senior Manager outlined the interventions taken by the Contract Monitoring Team to identify and prevent any decline in care standards.

RESOLVED:

(i) That the impact of 'Progress for Providers – Creating a Place Called Home Delivering What Matters' be noted; and

(ii) That the actions and initiatives underway to further develop the programme be supported.

25. ROTA VISITS

Councillor Hilary McGuill reported on her visit to Llys Gwenffrwd, Holywell, and said she had been impressed with the friendly and positive atmosphere in the home. She commented that residents felt valued and well cared for in a home from home environment.

In response to a concern raised by Councillor McGuill around parking at Llys Gwenffrwd, the Senior Manager Integrated Services Lead Adults/Early Years, said she had raised the matter with the Chief Officer (Housing and Assets) and assurances had been given that a member of his team would visit to look at the problem.

26. FORWARD WORK PROGRAMME

The Facilitator presented the Forward Work Programme for consideration. She advised that a budget workshop had been arranged for Members of the Committee on 10 October. A special meeting of the Committee was to be held on 31 October 2018 to consider the Stage 2 budget proposals.

The Facilitator referred to the meeting of the Committee scheduled for 15 November 2018, and said it had been agreed that it would be held at Llys Raddington, Flint. She explained that Members would have the opportunity to have a tour of the building prior to the meeting which would start at 3.00pm.

RESOLVED:

(a) That the Forward Work Programme be updated accordingly; and

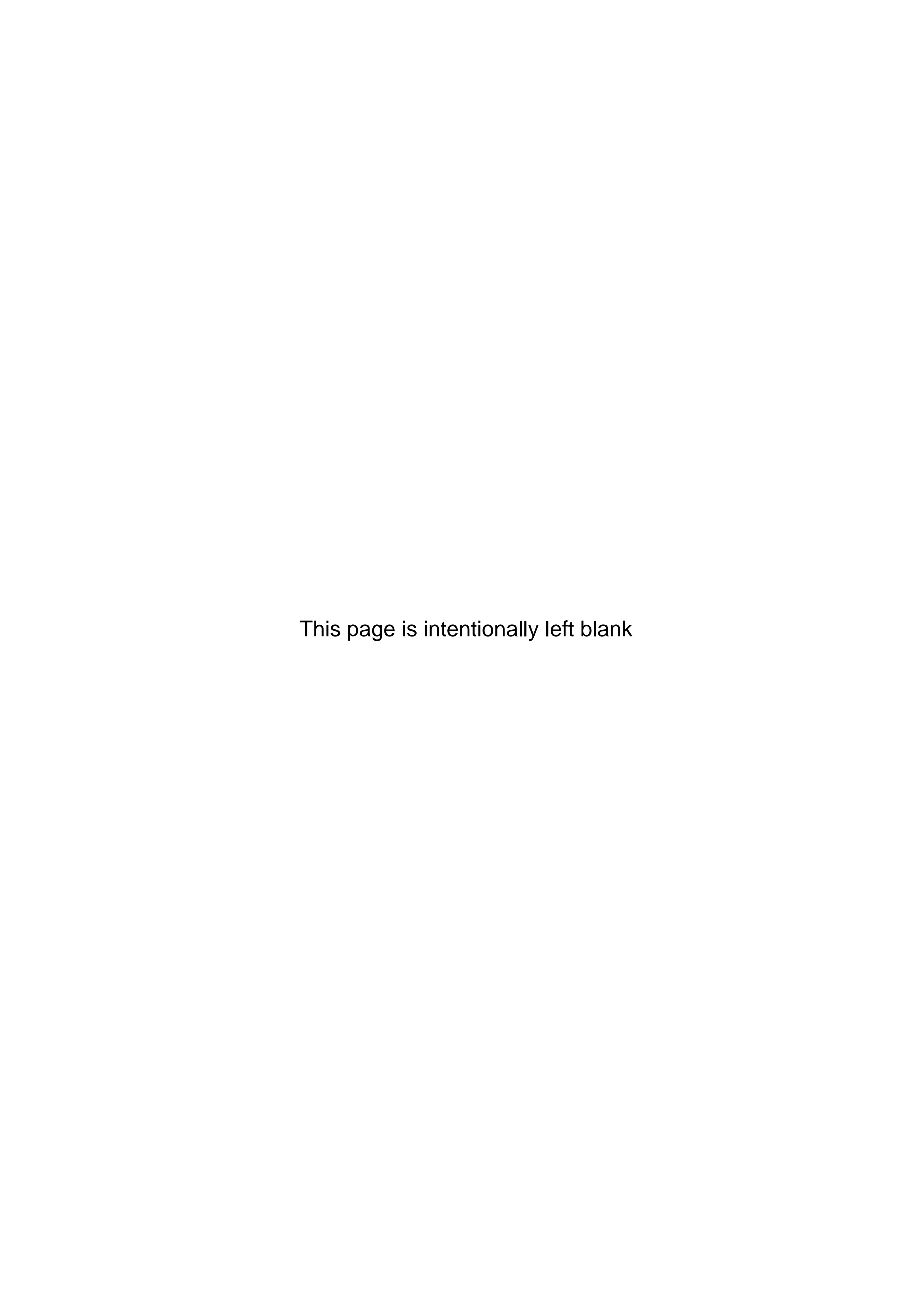
(b) That the Facilitator, in consultation with the Chair of the Committee, be authorised to vary the Forward Work Programme between meetings, as the need arises.

27. MEMBERS OF THE PUBLIC AND PRESS IN ATTENDANCE

There were no members of the press or public in attendance.

(The meeting started at 2.00 pm and ended at 4.25 pm)

…………………………
Chair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SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEEE

Date of Meeting	15th November 2018
Report Subject	Progression Team
Portfolio Holder	Cabinet Member for Social Services.
Report Author	Chief Officer Social Services
Type of Report	Operational

EXECUTIVE SUMMARY

This report is presented to Overview and Scrutiny Committee to highlight the work being undertaken to support people with disabilities to be more independent and rely less on paid support services, through the Progression Model.

The report identifies the positives of this work with a case study which nicely describes how the model works in practice.

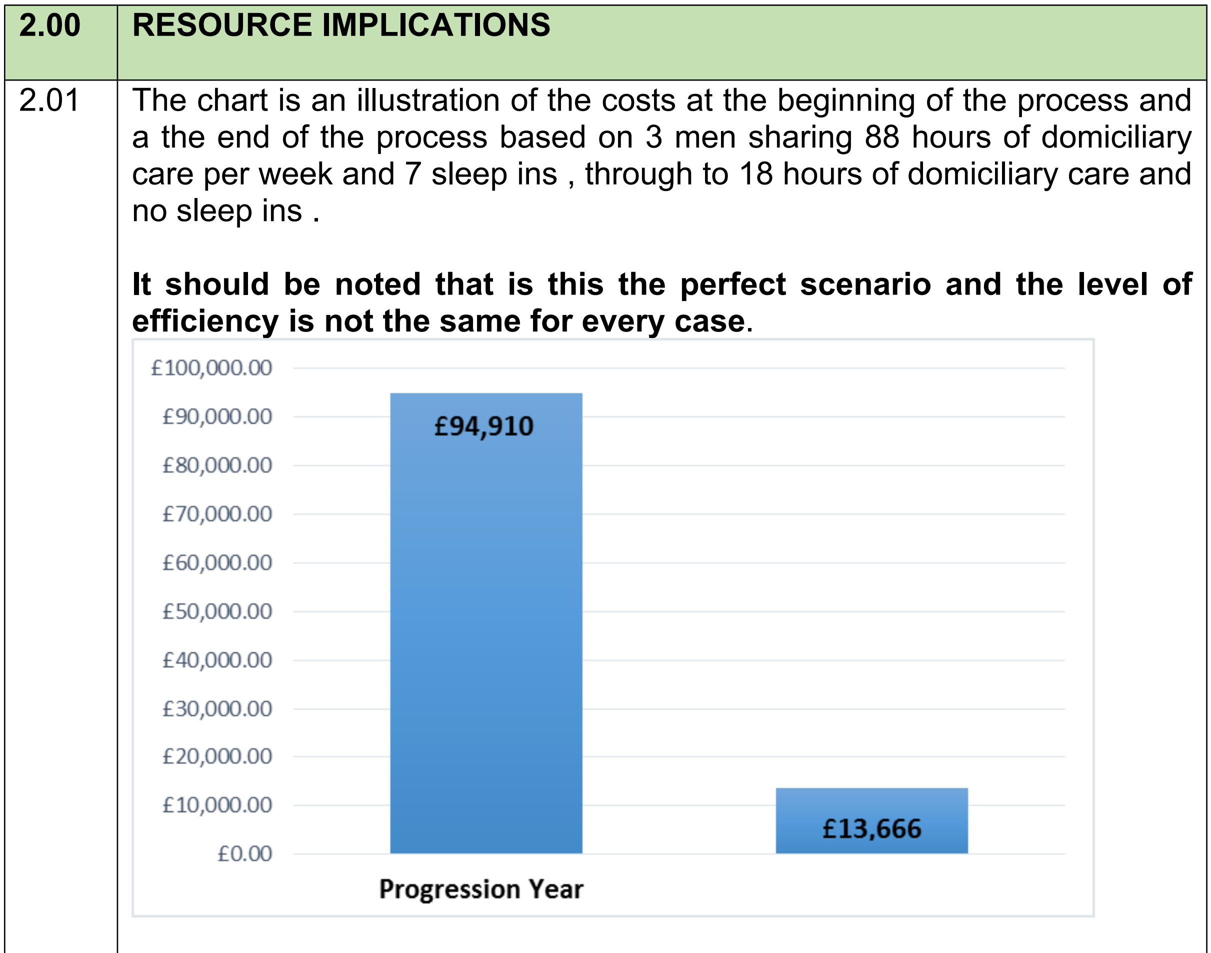
The progression model fits squarely with the principles as laid out the North Wales Leaning Disability Strategy which members endorsed in the October 2018.

RECOMMENDATIONS	
1	Committee Members become familiar with the Progression Model and the benefits this brings.
2	Committee Members support the expansion of the Progression Model and support officers to take forward change with service users, when family and friends may perceive there is risk to their loved ones, when taking this model forward.

REPORT DETAILS

1.00	**BACKGROUND**
1.01	During the 1980's significant investment was made in developing community support for people with learning disabilities, leading to the creation of supported living services as a wholly better alternative to residential or hospital care. The fixed model of 24 hour support was successful in improving people's quality of life.
1.02	People were and are still supported 24 hours a day, well cared for with few demands placed on them to reach potential and this model is generally popular with families. Whilst we will always have some people in receipt of this model of support, there is opportunity to change to a model supporting more independence for younger people, which is known as the Progression Model.
1.03	Over the years Flintshire County Council has gained positive recognition for developing highly person centred and strength based approaches. An example of this is the Direct Payment scheme which is commended nationally for its innovation and empowering people to have as much control over their support as they can manage. We will use this approach to take the progression model forward.
1.04	**What is the Progression Model and how does it work.**
1.05	The progression model is based on strength based assessments which maximise opportunities for independence, helping service users to acquire independent living skills. This means trained workers at all levels including social workers, occupational therapists and the direct workforce, develop a plan with an individual taking small steps to independence. This may cover everything from learning to travel independently on a bus, to making a sandwich.
1.06	The model has twin aims of maximising independence and making care affordable through the reduced reliance on longer term care.
1.07	We set about developing our Progression Model and made a commitment to challenge the barriers, attitudes and historical practice of being risk averse in culture, in order to develop a way that will maximise the lives of people with a learning disability and provide more life opportunities.
1.08	Flintshire County Council has worked in partnership with three young men and their families to develop a model of supported living aimed at increasing independence, positive risk with an enablement culture, using assistive technology and individually tailored support.

1.09	The three young men were initially assessed as needing eighty-eight hours of shared support per week and a 'sleep in' each night. The progression model was used to teach the young men some daily living skills. As an example, for approximately three to four weeks, the person working at night taught the men routine for locking-up, electrical safety and what to do in an emergency. Over time the young men learnt to do this themselves. We introduced assistive technology to support and once we were all confident in their ability to cope, the overnight support was no longer needed and was removed. The gentlemen learned many new skills and over time the eighty-eight shared support hours were gradually reduce to just eighteen hours per week. The individuals currently lead varied, independent and interesting lives.
1.10	**Current Situation.**
1.11	The Integrated Care Fund has allowed us to further develop this approach. We have a small team, comprising of health and social services staff, as well as Independent Care Sector care agencies.
1.12	With the support of a full time social worker and a Health funded part time occupational therapist working in a variety of settings with people to introduce the Progression Model, we have, over a six month period, supported 44 people using this model, all of whom are at different stages in the model. Even at this early stage we can report: • 20% have achieved what matters to them. • 80% reduction in the support provided; three ladies who moved into a new house in June this year, have progressed to not needing overnight support.
1.13	Use of the Progression Model recognises that not everyone can spend time alone and without support, but they can participate at their own skill level and still achieve what matters to them.
1.14	We are expanding the use of this model across Learning and Physical Disability Services and our aim is that eventually all support staff will be trained in this model and it will become the norm.
1.13	To date we have worked with new people in the services. The significant challenge will be to introduce the Progression Model into long standing supported living houses, where people have become used to the twenty four hour care and support.

2.00	**RESOURCE IMPLICATIONS**
2.01	The chart is an illustration of the costs at the beginning of the process and a the end of the process based on 3 men sharing 88 hours of domiciliary care per week and 7 sleep ins , through to 18 hours of domiciliary care and no sleep ins . **It should be noted that is this the perfect scenario and the level of efficiency is not the same for every case.** 

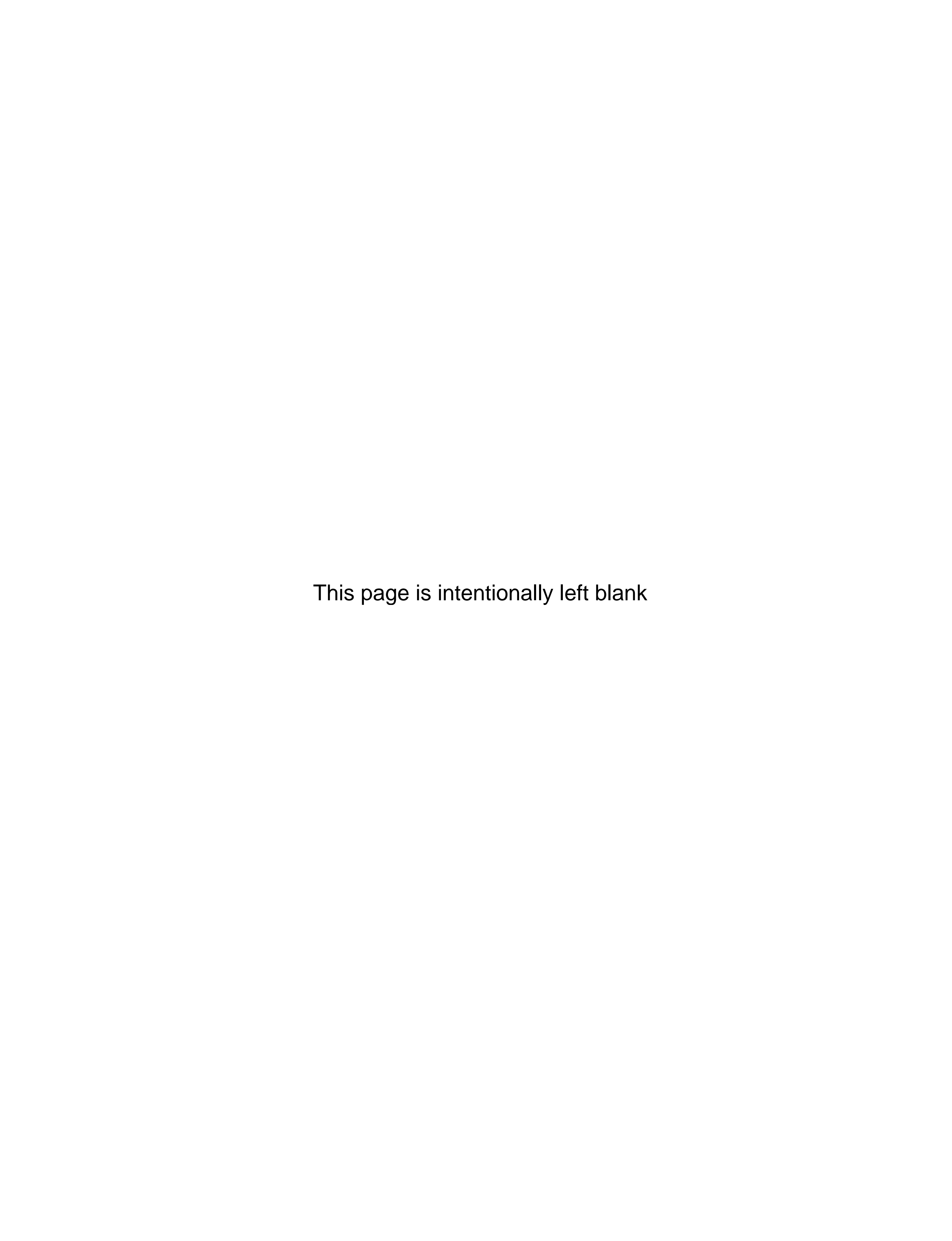
3.00	**CONSULTATIONS REQUIRED / CARRIED OUT**
3.01	The Progression Model operates in a fully, inclusive, co-produced environment with people and their families fully in control of plans.
3.02	The approach we are adapting for future supported living is that this model will always be used. This challenges some parents in positively managed risk.

4.00	**RISK MANAGEMENT**
4.01	As a direct result of this initiative, a Positive Risk Management Policy has been introduced across all Children's and Adult Social Services.

5.00	APPENDICES
5.01	Appendix 1 Progression Model Case Study

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS
6.01	**Contact Officer:** Jo Taylor – Adult Services Service Manager Disability Service

7.00	GLOSSARY OF TERMS
7.01	(1) Progression Model – a way of promoting and independence, learning daily living skills with small steps over time for people with a Learning Disability.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APPENDIX 1

PROGRESSION MODEL – CASE STUDY

- Three young individuals had lived at residential college and their placement was coming to an end.
- The individuals their families and advocates interviewed Providers and we were lucky enough to be given the opportunity to work with them.
- A property was identified and purchased by First Choice Housing and brought up to the relevant standard.
- Work was carried out to introduce the young individuals to their new neighbours and to build a relationship as part of the community.
- Information needed to be gathered for us to be able to put together a Service Delivery Plan. This would then help us to identify areas of abilities and the areas that would require support.
- A period of time was needed to get to know each other and establish routines.
- Once we had identified areas that we needed to work on, such as, security of the home, general house work, meal preparation and work / college placements.
- We then asked staff to start completing skills developments; this gave us clear indications of their abilities, as we did not want to work on areas they were familiar with. As you can imagine, being young, house work was not high on their list. For some, they had families that did the general day to day tasks around the home, so they were not expected to do this work.
- College placements had given the basic skills for cooking; but we needed to work with them to produce healthy meal plans, shopping and being able to budget.
- Cooking was enjoyed by them all and they were able to produce a basic meal and then clean up after themselves. We continue to advise and supervise meals, but we do give them the lead on the process.
- They keep their home clean and tidy; again some encouragement is required especially, on occasion, around their bedrooms.
- When we started to work around reducing support, we discussed with them how they would feel around having some time on their own in the house. This was met with a very positive reaction. We discussed with them having some equipment

placed around the house, which would keep them safe and help us provide the support in a more beneficial way.

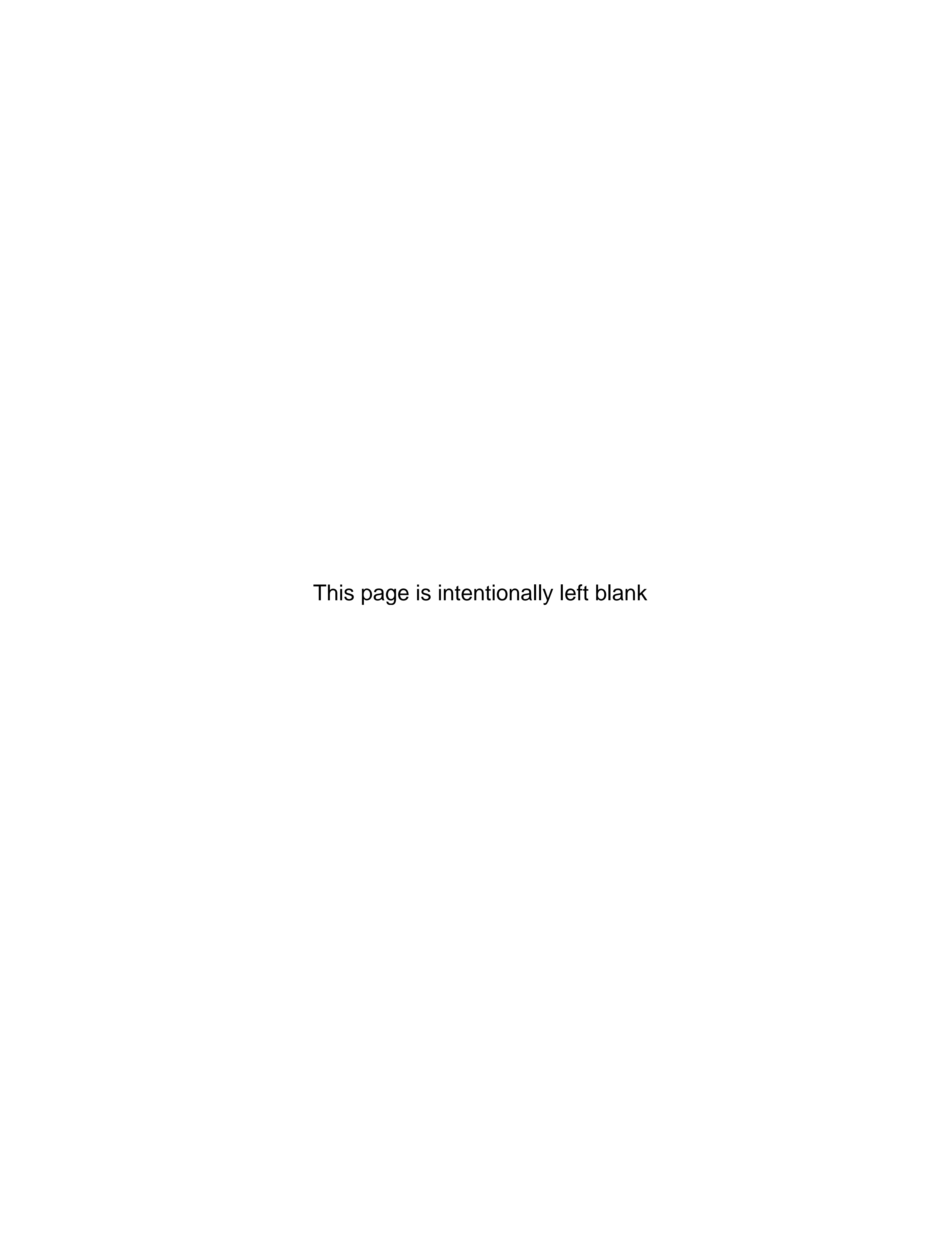
- We worked with other Professionals to ensure that all the work we were planning was done in a safe and positive way.
- Risk assessments were completed, time scales were looked at, ensuring that we worked at a pace that was acceptable to the individual.
- Over the next few months staff started to take a step back and direct them to perhaps ringing the office or lock the door and so forth.
- Staff set up contact numbers on the house phone and the individual's mobile phone if they had one.
- Staff took them to the bus stop to catch a bus rather than driving them to college.
- The staff then started to wait around the corner from the bus stop to ensure they got on the bus for college. On their return staff would wait to make sure they crossed the road and followed road safety. Once everyone was confident and happy they were able to do this safely, staff encouraged them to meet them at home. Eventually when we were confident that this could be done successfully we arranged for staff to meet them 15 minutes after their return home. We were able to build on this over a period of time, so now they go home and staff will arrive a couple of hours later.
- We then started to review morning routines to see what was required. Staff were reporting that that all three individuals were able to get up and sort themselves out to start the day. Although some work was needed to ensure they closed the door when they left the house.
- We then spoke to work opportunities due to them collecting one or two of the individuals. They also ensured that the door was locked on leaving and worked with us around dropping off in the evenings from their placement, again making sure they were in the house and the door was locked.
- The individuals knew how to contact the office should the mini bus be late, this enabled us to liaise with the work placement.
- They also contacted the office should they have any concerns.
- Over the last 12 months we have worked with the three individuals, creating independence and a good skill base, which enables them to have a longer period of time to live independently.

- This works well for the individual as the staff know what is required to support the individuals when they commence their shift.

- We now only target support where required although we do assist the individual with social activities.

- Staff are still working with all three around night security. On arrival for the night shift, staff are finding that all three are in their own rooms and some mornings they leave without seeing them.

- We would now like to work with the individual's families, advocates and other professionals to look at night time support.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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

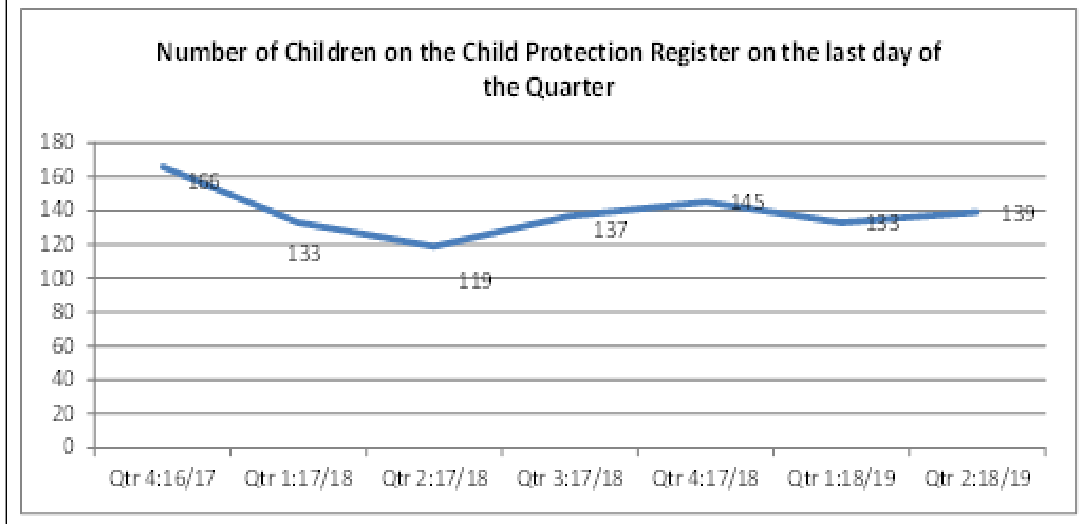
	Safeguarding Unit and the continuing development and improvement in service provision.

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.'

10 Top Tips for Making an Adult Safeguarding Report

The form is to be used only for reporting suspected abuse or neglect of an adult at risk to social services. If you want to let social services know other information or to request services or support, please contact the appropriate social services department.

It is important to give as much information as possible in the report form. If you do not give a full account of what has happened, the process of protecting the adult at risk may be delayed.

The following ten tips should help you complete the report:

1. Correctly Recording the Basic Information
   - Name, address and date of birth of the adult at risk;
   - Address and Telephone Contact details.
   - Gender and ethnic origin of the adult at risk;
   - Care and Support need of the adult at risk;

2. Make clear who you are, what your role and relationship is to the person you are making the referral about.
   - **Include where the adult at risk is now and what actions have been taken to ensure the safety of that adult.**

3. State the source of your evidence and be clear what is fact and what is opinion.
   - Is it from the notes, first-hand experience of your interaction with the person, concerns raised by other professionals or 3rd party information? It may be a combination of all.

- Quote exactly what the Adult at Risk has said to you.
- For example, don't write 'the Adult at Risk says his partner is being physically abusive towards him'; quote exactly what the Adult at Risk said: "my partner pushed me down the stairs last Tuesday and then dragged me along the floor by my hair".

4. Be concise and use short sentences. Explain medical terminology and what this means for the Adult at Risk, as the reader of the referral may not have any medical background.
    - For example, you are making an Adult Safeguarding Referral because you have been made aware that Richard's carers have not been giving him his thyroid medication. You could write: 'Richard has hypothyroidism (underactive thyroid) and needs to take his prescribed medication (Levothyroxine) daily. If he does not have his medication daily he could become very unwell. Richard has a learning disability and relies on his carers.

5. Describe what has happened with as much detail as you can and if there were any witnesses.

6. Be clear about what type of abuse you think has occurred.

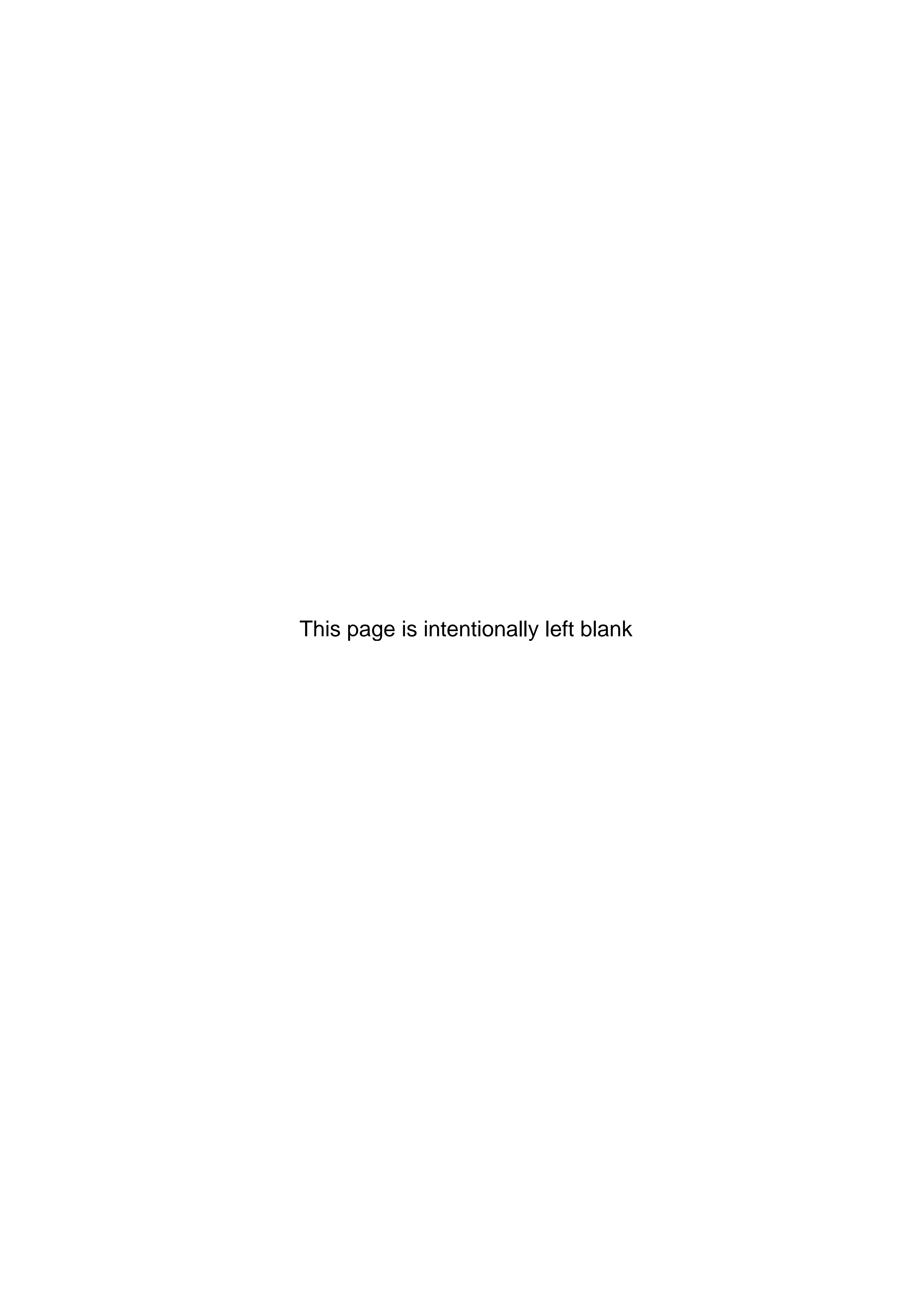
7. Include as many details about the perpetrator/s as you can

Do not contact the perpetrator yourself

8. Consider whether there is anyone else at risk
    - For example, children or other Adults at Risk, and state this and who they are.

- Consider whether you need to make a Child Safeguarding Referral.

9. State whether the Adult at risk is aware of the safeguarding concern and what the Adult at Risk would like to happen.
    - It should only be in exceptional circumstances that the Adult at Risk (or their family/Power of Attorney if appropriate in cases where the Adult at Risk does not have capacity) should not be told of your concerns. **Remember Safeguarding should be a process done WITH Adult at Risk, not TO them.** Exceptions would be that if by telling the Adult at Risk your concern it would put the patient or yourself at risk of harm.
10. Document clearly in your own agency notes what actions has been taken.



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Reporting Safeguarding Concerns

Safeguarding is everybody's business

Keeping people safe

Protecting vulnerable children and adults

I have a concern about a child or an adult

Make sure the child or adult is not at immediate risk of harm

If you have an immediate concern consider contacting the police on 999 or 101

Speak to your line manager or to the safeguarding lead in your team who will make a safeguarding referral if needed

If there is an issue out of hours you can contact the Emergency Duty Team on 0345 053 3116

Contact Children's First Contact Team on 01352 701000

To make a child protection referral or discuss a concern about a child

Contact SPOA (single point of access) Team on 01352 803444

To make a adult protection referral or discuss a concern about an adult

Contact Adult and Children's Safeguarding Unit on 01352 702601

To obtain advice, guidance or assistance on general safeguarding issues

Believe that abuse can happen & never ignore a hunch

Report and record your suspicions as soon as possible

Do not tackle an alleged perpetrator yourself

Share your concerns with your manager or other appropriate person

Know the limits of your responsibility

If possible inform the individual you are concerned about what the process and next steps will be

Do not cover up for others

Ensure that you know the Policy & Procedures

Keep up to date

Further information on Safeguarding

- For more information on safeguarding policies and procedures, training opportunities and general information, visit the **Regional Safeguarding Board website** North Wales Safeguarding Board

- To contact the **Children's First Contact Team**
  childprotectionreferral@flintshire.gov.uk
- To contact **SPOA (single point of access for adults)**
  SSDUTY@flintshire.gov.uk
- To contact **Flintshire Safeguarding Unit** for general advice
  ChildrensSafeguarding@flintshire.gov.uk
  Adult.Safeguarding@flintshire.gov.uk
  LookedAfterChildren@flintshire.gov.uk

Flintshire Community Safety Partnership- Domestic Homicide Review

Executive Summary of the Overview Report

Into the homicide of Marie on 14th September 2014

2017

Panel Chair: Jenny Williams: Strategic Director of Social Care and Education Services, Conwy.

Independent Author: Sue Maskell. MA AASW CQSW

Acknowledgement

It is very important for us to acknowledge that in producing such a report as this we are looking at the circumstances of the life and death of someone who was valued and dear to her family members and that the family are left to deal with their shock and sorrow. We can only hope that our efforts to learn lessons from the tragic loss of their family member Marie (pseudonym), has not added to their distress. So, in the production of this report agencies have collated sensitive and personal information under conditions of strict confidentiality; balancing the need to maintain the privacy of the family and the need for agencies to learn those lessons related to practice, which have been identified during the review of this case and also of course, acknowledging that this report will become public as is required by the Home Office.

Additionally, and perhaps unusually we have contacted and/or interviewed past partners of the offender, who came forward to the police after the murder of Marie. We are grateful for their willingness to be engaged in this process, knowing the distress that they experienced in doing so. It is important to acknowledge that it is their expressed and firm wish that lessons might be learned from their experiences and that these lessons might prevent harm occurring to others.

1. INTRODUCTION

1.1. This Domestic Homicide Review examined the circumstances surrounding the death of Marie (pseudonym). Marie was a 45 year old woman who lived in a small rural village in Flintshire. Marie was murdered on the 14th September 2014. Marie was divorced and she had never lived and with the offender (P1).

1.2. Marie was a much loved family member she had two children and she also had a mother, siblings, nieces and nephews, who all live in the local area. So Marie was a mother, a sister, a daughter and an aunt, she is sorely missed by her children and her family. Marie had a stable home life and worked for a company in a nearby town.

1.3. During the course of the police investigation it was established that Marie had only recently met P1, the man who murdered her. They met through an internet dating site, which is not unusual these days. They had been seeing each other for only a few weeks prior to Marie's death, the exact time being unclear, but estimated to be between four and six weeks. The relationship was therefore in its earliest stages and P1 and Marie did not live together.

1.4. On the 13th September 2014 Marie had been out with her nephew to a public house in a nearby town and P1 joined them there. It was stated to the report author, by a family member, that Marie had mentioned that P1 was a jealous man and possessive, and so it is thought by her family that Marie had intended to end her relationship with P1. Given that is the view of the family; it is interesting that although P1 had joined Marie at the public house. Marie then returned without him to her home, being taken there by her nephew in the early evening as Marie was due into work the next day. It appears though, that shortly afterwards P1 arrived at Marie's home.

1.5. A 999 call was made from the mobile phone of Marie after her return home from the public house. The telecommunications operator said they could not hear anything and so the call was not forwarded to any emergency service. During the course of the DHR the police were asked again to check the circumstances of this call.

1.6. The police told the report author that after Marie's death, a transcript of the 999 call was made by North Wales Police. This transcript could only be made from a significantly enhanced audio and even after that significant enhancement, the call was still not clear. Unfortunately, the evidence is that the operator would not have been able to hear what was being said by Marie or P1 at the time. The call was made at 19.07 hours on 13th September and lasted only 12 seconds. There is nothing to be heard in the transcript to indicate whether Marie was asking for help during the call.

1.7. P1 attacked Marie on the evening of 13th September 2014. During the course of the attack he assaulted and strangled her. P1 admitted that he had waited to call an ambulance and this was indeed mentioned in the Judge's summing up at the sentencing

hearing. P1, when he was interviewed for the purpose of this DHR, confirmed unsolicited, that he waited a long time to call the ambulance.

- **At 02:35 hours on 14th September 2014 the Welsh Ambulance Service received an emergency call from a man, now known to be P1, who stated that he had found his girlfriend (Marie) unconscious on the floor after she had been drinking, the caller was given advice regarding resuscitation.**

- **A Community First Responder (CFR) was dispatched to attend and was the first person to arrive at the home at 02.50hrs**

- **At 02.57hrs the CFR confirmed that Marie was in cardiac arrest. After the ambulance arrived advanced life support resuscitation was initiated, however, tragically at 03.09hrs Marie was confirmed to be dead.**

- **At 03.11hrs the police were informed of the incident and arrived at the address at 03.35hrs.**

- **At 03.44hrs, following initial enquiries; P1 was arrested on suspicion of the murder of Marie.**

- **At 18.31hrs on 16th September 2014, P1 was formally charged with the murder of Marie and was remanded in custody, pending a Crown Court appearance.**

1.8. Subsequently, on 19th December 2014, P1 appeared before Crown Court where he pleaded guilty to the murder of Marie and he was sentenced to life imprisonment with a recommendation that he must serve at least 17 and half years before he is considered for release. In his sentencing address the Judge said that Marie had died as a result of asphyxiation and strangulation and she had been severely beaten in a ferocious attack.

2. The Review Process

2.1. This summary outlines the process undertaken by the Flintshire Domestic Homicide Review Panel in reviewing the death of Marie.

2.2. On the 26th September 2014 Flintshire Community Safety Partnership convened an extraordinary meeting at which it was agreed that the circumstances of the death of Marie met the criteria for a Domestic Homicide Review and that a review should be conducted in accordance with Home Office Guidance and the guidance developed by Flintshire Community Safety Partnership.

2.3. On the 29th September 2014, the Chair of the Flintshire Community Safety Partnership, the CEO of Flintshire County Council, formally notified the Home Office of the intention to carry out a Domestic Homicide Review.

2.4. At the first panel meeting it was reported by North Wales Police that proceedings had been initiated in relation to offences committed against five further women who had come forward following the reporting of the murder of Marie and who reported being the victim of domestic violence related offences committed against them by P1.

2.5. As a result of the investigations that were conducted into their accounts, P1 was additionally charged with seven charges of Actual Bodily Harm in respect of 4 of the Victims. At his court appearance P1 pleaded 'not guilty' to these additional charges. As a result of his guilty plea to the offence of murder, a decision was made that the seven additional charges would not be proceeded with and were ordered to 'lie on file'.

2.6. It was agreed in a panel meeting in January 2015, to communicate with the Chief Crown Prosecutor in Wales, outlining the panel's wish to extend the parameters of the DHR to encompass the period of the relationships that P1 had with the additional alleged victims. In order for the Panel to do this, authority was sought from the Chief Crown Prosecutor to include in the DHR those 7 prosecution cases that had been ordered to 'lie on file'. The Chief Crown Prosecutor provided his authority for the cases to form part of the review.

2.7. During the subsequent initial review of these cases it was identified by the panel that some of the relationships dated back to 1991. So, the panel agreed that the review would remain focused on the period from 1st May 2005 to 14th September 2014. The reason for this decision was that the panel had concluded that processes and procedures had changed significantly since 2005 and so the context of the reported earlier assaults would be measured against processes that had by now been significantly changed and therefore any lessons likely to be learned would in fact already have resulted in changed law, policy and practice.

2.8. However, this notwithstanding, there was an exception and this was because after the DHR report author accessed the statements, made by 5 of the women who came forward, it was found that, allegedly, P1 continued to make serious threats to the woman known hereafter as V2. So, although V 2's relationship with P1 took place before the 2005 timescale of the review (V2 was P1's first wife), panel agreed that V2 should be offered an interview as part of this process; an offer which V2 accepted.

2.9. The panel were eventually informed that a total of eight women approached North Wales Police after the death of Marie was reported in the press. Whilst seven of these women had provided formal written statements to the police; one woman was spoken to by police but declined the opportunity to provide a formal written statement.

2.10. Again with the agreement of the Chief Crown Prosecutor the independent author was given access to all of the statements, and to the written record of the conversation with the woman who did not wish to make a formal statement. Two of the statements and the written record were read by the author later than the first 5 and were considered by the panel to be in the category of additional information, largely because they did not result in any charges being brought as part of the proceedings following the death of Marie.

2.11. It was agreed by panel, following review of all the statements by the report author, that three of the original 5 women who had made statements should be approached and asked if they would be willing to be interviewed as part of the DHR. Of these 5 women, four had made statements resulting in 7 charges. In addition all five women would be asked for their consent to use the information they had given to the police as part of this review. Each gave their written consent.

2.12. Three women were interviewed directly by the independent author, two in the company of another panel member. We offered to see one woman, V3 with the DHR report later but she declined that opportunity. A further woman, V1, was spoken to by telephone. No charge was filed in respect of an alleged assault on V1 who first knew P1 in childhood; she met him again within the timeframe of the DHR, via the internet.

2.13. A further issue arose when the panel were informed, as a result of reading statements, together with the information contained in a timeline prepared by the police, that there had been a child protection case conference in respect of the children of another former wife of P1. (Hereafter, the former wife of his second marriage will be called V3) Although, this conference took place outside of the time period that was subject of the review, the fact that that there had been a child involved by P1 in an incident of Domestic Abuse, led the panel to request the case conference report so that it could be considered as part of the DHR. It was January 2016 before the minutes of the conference were obtained due to issues around gaining consent and also being certain in which authority the case conference occurred.

2.14. The result of having access to the above information can be summarised like this:

A. Had other witnesses not come forward, the homicide of Marie would have resulted in a brief DHR due to the fact that the relationship of P1 and Marie lasted only about 4 to 6 weeks The fact that the statements made by other witnesses resulted in seven charges which were left on file, indicated that there may be lessons to be learned about the response to and management of cases of Domestic Abuse across the agencies prior to the homicide of Marie, the link in all these cases being P1.

B. Panel recognised that the potential lessons to be learned arise during a period where law, processes and procedures concerning Domestic Abuse have been modernised and where attitudes have changed, both in the professions and amongst the general public.

C. Given there was a Child Protection Case Conference, the Panel believed that there may also be lessons to be learned in the child protection field, even though this conference fell outside the original timescale of the review. Nevertheless, it fell within a period when the impact of Domestic Abuse and its connection to child abuse was already recognised.

D. It was the murder of Marie that led to this DHR and so in exploring the other information given by the women it was agreed that a full review of their cases would not result, but even so, if necessary, other agencies involved with the witnesses would be asked to contribute and supply information for panel to review.

2.15. The process of the DHR began in January 2015 but due to the above circumstances it was delayed and at that time a report author had not yet been appointed. The review was underway by June 2015 when the report author attended her first meeting with the panel.

2.16. This is an unusual DHR report because the scope of the Domestic Homicide Review widened due to the number of witnesses that came forward after the tragic death of Marie in September 2014, at the hands of P1. The report also took longer than expected to complete due to the information that came to light during the review and which panel decided should be considered as part of the review. The full detail of the various reasons for delay is laid out in the main report in the appendix which contains the terms of reference.

2.17. The Family

As part of this DHR the family of Marie were offered the opportunity to participate in the review. The offer was initially made by officers from North Wales Police who had supported the family during the investigation. Then through letters from the Chair of the DHR Panel with the Home Office leaflet attached. The communication led to the author of the report meeting with Marie's sister. It was agreed with the sister of Marie that if other

family members wanted to participate directly then that would be arranged and she agreed to tell them about this and she was given further leaflets to enable the family to understand the process and purpose of participation in the review. The author met with Marie's sister again to go through the report and recommendations with her in July 2016. Since then the family have been kept up to date by letter.

2.18. Although a meeting had initially been arranged with the ex-husband of Marie who is the father of her children, he did not attend as arranged. However, he and his children were offered a further opportunity to do so. He asked to meet with the author when the report was completed and this meeting did take place, he told us that he had made the children aware of this process and talked to them about it. The report author showed him the report content, which applied to Marie and the recommendations of the review.

2.19. At the first meeting with Marie's sister, who said she was representing Marie's family, the main issue raised was about the silent 999 call that we believe Marie made on the night of her murder. The fact a call was made is very distressing for the family, who think that Marie would have been hoping that help would come and yet that hope was in vain. The panel debated this issue at some length and have made a recommendation in regard to the use of mobile phones to call for help, which follows at the end of this summary. After the Quality Assurance process by the Home Office, it was suggested that we should consider referencing the Silent Solutions Scheme and we have done this. Though we should be clear that the call Marie made was of only 12 seconds duration and the operator could not hear and request. This system seems little known about by the general public and many professionals. Clearly that situation needs resolution as recommended by the IPCC in late 2016, after completion of this report.

Other participants and offers of participation

2.20. The adult children of P1 were also offered an opportunity to participate. This approach was facilitated through their mother. The offer was declined.

2.21. The offender, P1 was also interviewed as part of this review. He made two main points. To summarise; one point was that he thought that internet dating was fraught with issues and that people rarely told the truth about themselves and he thought therefore that there should be more protection on these sites and more information about the risk. The second had to do with mental health. P1 felt that he should have been more persistent in seeking help for his own mental distress and that he should not have said he was doing fine when in fact he was not. P1 also thought mental health services were not given sufficient priority.

2.22. The agencies participating in the review are:-

- **Aneurin Bevan University Health Board (ABUHB)**
- **Betsi Cadwalader University Health Board (BCUHB)**
- **Employer of Marie**
- **Employer of P1**
- **Flintshire County Council Social Services**
- **Flintshire County Council Education Service**
- **National Probation Service**
- **North Wales Police**
- **North Wales Fire and Rescue Service**
- **Sandbach Health**
- **The Royal British Legion**
- **Welsh Ambulance Service**
- **Wrexham Local Authority Children's Services**
- **CPS who gave consent to use the statements relating to offences which remain on file**

2.23. Agencies were asked to give chronological accounts of their contacts with the victim and/or perpetrator prior to the homicide. Where agencies had no involvement or no significant involvement, they informed the review accordingly. In line with the terms of reference, the DHR covered a ten year period prior to the death of Marie. Additionally, the review explored the case conference, which took place in 2001, which was outside of the original timeline set but which the panel felt was relevant to the history of the offender.

2.24. Only one of the above listed North Wales agencies had no contact with the victim or perpetrator and that agency was the North Wales Fire and Rescue Service. Of those contacted none had any kind of contact with Marie during the time that she knew P1, outside of that which is normal, i.e. school or GP contact, until they were called to her home on the night of her murder. Eight agencies had contact with P1. Again none of these contacts occurred during his relationship with Marie until the night of her murder. So with the exception of the normal contact a person would have with their employer, there was no agency involvement with either the victim Marie, or the perpetrator P1 during the short duration of their relationship.

3 Terms of Reference

3.1. The Purpose of the Domestic Homicide Review is to:

- **Establish what lessons can be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;**

- **Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;**
- **Apply those lessons to service responses including changes to policies and procedures as appropriate; and**
- **Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and interagency working.**

(The full Terms of Reference are appended to the DHR report)

4. Key Issues

4.1. The DHR provided an opportunity to analyse information obtained from the agencies, the family of Marie, the perpetrator, and the previous partners of the perpetrator whose statements to the police after Marie's death resulted in the 7 charges which remain on file.

4.2. In particular Marie's Family asked the review to consider the issues which arise from the use of silent 999 calls to call for help. The panel did debate this at some length and have made a recommendation regarding silent 999 calls. We also after the Home Office letter, considered the Silent Solutions Scheme as referred to in the conclusion of this summary report.

4.3. The review also considered whether any of the nine protected characteristics of the Equality Act influenced decisions made by organisations in their contacts with Marie, The Perpetrator and the other victims we interviewed during the review. The panel is satisfied that there were no equality issues.

4.4. In regard to the first three purposes of Domestic Homicide Reviews stated above, we found:

- **There were no reports of Domestic Abuse to any agency during Marie's brief relationship with P1. There was no indication through the normal involvement that people have with their place of work or their GP, or in relation to the child still at school (in any of his contact with the school), that anything was amiss. Therefore, there was no mechanism for agencies to communicate with either Marie or each other during Marie's relationship with P1.**
- **We did not identify any trigger that would have caused Marie to communicate with agencies or to ask for help, before the night of her death, when it is believed she made a brief and silent 999 call.**
- **There is no evidence, that we know of, that any agency had any cause to act, or that any agency missed any opportunity to identify that there was anything amiss in Marie's life. This was such a brief relationship that, as stated above, agencies**

had not received any reports of any incidents or concerns, which would have prompted any intervention.

- **Given the length of the relationship and the lack of any evidence that there was cause either for Marie to contact an agency or for an agency to contact her, we did not find that any action on the part of any agency could have prevented the death of Marie. We have taken account of hindsight bias and we have concluded that in the case of the death of Marie, there was nothing that the agencies could have done to prevent her murder.**
- **Even if P1's past had been thoroughly collated in records the serious nature of P1's behaviour would not be apparent to anyone, unless Marie, or a third party who was concerned for her, or her children's safety had cause to use the DVDS or CSODS schemes. We have not found any evidence that Marie had cause to make any checks on P1 in the few weeks she knew him. Neither have we found any evidence to suggest that any agency came into contact with Marie during that period of time and had cause themselves to make any background checks on P1 or to advise Marie of any risk that she may be subject to.**
- **Even if Marie had cause to make any check on P1, with the police for instance, there would have been no record available of his activities pre 2005 on the Police National Computer if the incident had not resulted in a charge. However, details of these incidents would be available on local police systems and dependent on their nature i.e. if they involved child protection / domestic abuse issues may also have be recorded on the Police National Database (PND), if the force where the incident occurred had an electronic record of the incident on their systems .**

4.5. If there is one thing we have learned from this review it is that recording offending behaviour really matters, as does the ability of statutory agencies to access that information. Had today's system been in place in 2001 it would have captured the offences for which P1 was charged, but not convicted, in Wrexham and improved information sharing between agencies, when he committed an offence of Common Assault in Flintshire in 2006.

5. Lessons to be learned/Prevention of Further Domestic Homicides

In regard to the fourth purpose of the DHR, the prevention of further domestic homicides and domestic abuse, we made three main findings in relation to the murder of Marie.

5.1. Silent 999 calls

5.1.1: Marie, we believe, must have been concerned for her own safety that night the 13th September 2014, as it is believed that she was the person who telephoned 999 to get help at 19.07 hours. We do not know if she attempted to speak and was prevented from doing so by P1, or whether she made a silent call believing that someone would understand from the call that she needed help and would be able to trace the call and come to her

aid. The enhancement of the recorded call does not assist us further in reaching a conclusion.

5.1.2: It is an urban myth, probably supported by TV programmes, that silent 999 calls always produce an emergency response. It has become customary for parents for instance, to give children mobile phones so that they know where their children are and most of us believe that if the child phoned 999 they would somehow be traced if in need of rescue. This is clearly not the case because, as we have discovered, there are many 'silent calls' in a day and these are not all passed to the police. (We note that there are numerous commercially available 'location sharing applications' for smartphones, which when installed to on to the mobile phone, enable users to identify the locations of others and share their own location via the App and some people install this on their children's phones).

5.1.3: The volume of silent calls (up to 30 million emergency calls per annum, thousands of these are not emergencies but are made by children or accidental calls), means that any plan to trace them is not sustainable within the resources likely to be needed. The other point to make is that whereas a landline can be traced to an address, a mobile would only be traceable to an area covered by a mobile phone. Some mobiles, 'Pay as You Go', are not registered in the same way as contracted phones. Therefore, the protection for potential victims and their families can only lie in debunking the myth that help will always come if any of us make a silent 999 call. We acknowledge, following the Home Office's comments that a system called Silent Solutions is in place. However, this system seems little known about by the general public and many professionals. Clearly that situation needs resolution as recommended by the IPCC in late 2016, after completion of this report.

5.1.4: The DHR Panel have discussed this matter at some length and are of the opinion that if Marie made the silent 999 call herself, then it was with the expectation that she would be helped. This view is probably held by a large number of people and so for safety's sake it is important that the message is given nationally that silent 999 calls, especially from mobiles, are not guaranteed to bring help. In extreme need and lacking the ability to speak, which would apply to Marie, the Silent Solutions system may help, but as stated above that system needs much more publicity for both the public and professionals. Furthermore, in this case the silent call was extremely brief lasting 12 seconds.

5.2. Internet Dating

The panel recognised that there are risks associated with meeting any new partner but these risks may be to some extent increased by the use of social media, which facilitates offenders in finding new victims over wide geographical areas. We concluded that more

public information about keeping safe on line and about taking precautions when meeting new people is needed, given the proliferation of this method of dating.

5.3. Offender contact with General Practice

5.3.1. The last two recommendations in regard to the section of the review, which applies solely to the murder of Marie, arose from the chronological history of the offender's consultation with his GPs. As stated above, P1 was interviewed as part of this review and gave consent to access his health records. P1 said that he should have been more persistent in seeking help for his problems, which he defined as mental health issues. The review found that there was some evidence that P1 had indeed from time to time sought help. Firstly he sought help of his own volition, from a substance misuse service in 2001 when he was offered an appointment, which he did not attend. He then sought help from time to time through his GP for what might be termed mental distress; often this appears from the information we had, to coincide with the time that relationships ended. We found that he did not follow through in terms of his engagement with services when referred by his GP, which led to case closure by a mental health access team, when he told staff that he was managing. He has stated that he now regrets that he was not more insistent with staff that he needed help. He is also adamant that he suffered from PTSD but we found no evidence of formal diagnosis of PTSD we found only self-report by P1 to his GP and to the women he met. It is important to note that when P1 last saw a GP it was regarding a physical problem in July 2013 not a mental health issue.

5.3.2. So, in the light of the above information the panel concluded that there is potential to consider the role of GPs and other Health Workers when patients report to their GP that they experience angry outbursts and mention that allegations of violence have previously been made against them. Panel noted that this issue arose in a previous DHR presented to the Home Office and that there is guidance for GPs when a person reports they are being abused but guidance is less clear when a person reports characteristics and events, which indicate they may be a risk to others. So we recommend that nationally the role of GPs and Health Workers in reporting potential Domestic Abuse is considered in terms of both developing guidelines for GPs and Health workers and also GP training in this regard. Locally plans are now in place for training (see BCUHB recommendations). We also recognised that the legal and ethical limits on patient confidentiality may be an issue for staff and so we recommend these are re-considered in terms of Health Professionals being given clear guidance about how to manage when Domestic Abuse issues arise in discussion with their patients or are indicated by their patient's presentation.

5.3.3. As stated above it is important to be clear that a DHR is not an enquiry into how a victim dies or into who is culpable, as those matters are for Coroners and criminal courts to determine. In this case however, P1 admitted he murdered Marie and he was sentenced to serve a minimum term of 17 and half years in prison.

Lessons Learned for the remainder of the Domestic Homicide Review

6.1. The remainder of the DHR explored the previous relationships of P1, which provided an extensive insight into his history; it also provided a background context for his behaviour towards Marie, which tragically led to her death.

6.2. During the timescale set by the panel in the terms of reference for the DHR, (which was the ten years before Marie's death in September 2014); the panel became aware of 8 women, in addition to Marie, who had some involvement with P1. Some relationships are reported to be very brief, lasting for only a month or few weeks. Others lasted 6 months or a year most were not 'live in' relationships. P1 was twice married prior to the timeframe of the review, though one divorce coincided with the start year of the 10 year timeframe.

6.3. Five women report having met P1 on line, adding to the importance of the recommendation made by panel about the use of internet dating sites. One of these women was in contact with P1 having not seen him since her youth. This woman, V1, said she ended the relationship swiftly, after being assaulted by P1 in front of another person. All the women mention in their statements to the police that they, not P1, ended their relationships.

6.4. When P1 was interviewed by the report author he mentioned that he had suffered from PTSD (see above). Some of the statements made by the women, who contacted the police after the death of Marie, also mention that P1 told them he suffered PTSD. He also spoke to us of being emotionally abused by his father when a child. We were told that he gave the women he met various reasons for the alleged PTSD; according to the women, these reasons ranged from childhood abuse, to losing his first wife and children through divorce, trauma in service with the RAF and suffering Domestic Abuse himself. PTSD was, according to the medical records we have seen, never formally diagnosed, so it appears that PTSD was a self-reported condition.

6.5. This report illustrates that P1 was skilled at the grooming and control of both individuals and environments. P1 would hide his behaviour in the plain sight; not only of his victims but of his work colleagues too, this was part of P1's grooming process. We found evidence that P1's offending behaviour stretches over 23 years and in that time we were told that he had assaulted and controlled his victims and caused fear and alarm to children and in the case of one child, physical injury. The evidence we have seen indicates that P1 had a modus operandi, which was about seduction and possession and control, which eventually led to alleged serious assault of at least 4 women, an actual conviction for assault in 2007 and eventually to Marie's tragic death.

6.6. It is important to restate here that the DHR does not have the purpose of enquiring into how a victim died, or into who is culpable, as those matters are for Coroners and

criminal courts to determine. So therefore, similarly, in terms of the Panel looking at the past relationships of P1, it is with the intention of exploring whether lessons could be learned by agencies, which may help future victims of Domestic Abuse and prevent homicides and not to allocate culpability. The DHR focused upon the five women from whom the police took statements of complaint that led to the 7 charges in respect of four of them, these charges still remain on file. These women were called by Panel, V1 to V5. Consent was gained from these women to use the information they gave within the DHR.

6.7. P1 entered a plea of not guilty to the additional 7 assault charges made against him. Following his guilty plea to the murder of Marie these charges remain 'on file'. This review explored the information given to it and could not comment on the veracity, or otherwise of the information given, since the cases remain on file. So this information is used acknowledging that whatever the outcome of any potential future hearing, the women who participated told of their own experience and their own reality, for which the panel is very grateful.

6.8. From the evidence gathered during the DHR there were four major areas that the panel and therefore the report focused upon:

<u>7. The first additional area covered by the review: A Child Protection Case Conference 2001.</u>

7.1. The First area explored by the DHR Panel was a Child Protection Case Conference in Wrexham in 2001. The Child Protection Case Conference took place due to a violent incident attended by the police. The conference occurred much earlier than the review timeline but panel felt this event was relevant to the DHR, as evidence of the length of time over which the behaviour of P1 (which finally led to the homicide of Marie) persisted and in particular because a child was recorded as being injured on the occasion that the Child Protection Case Conference covered. P1.was charged in relation to these injuries but the case did not proceed.

7.2. We acknowledge in the DHR that since 2001 there have been many changes to practice, policy and procedure. Indeed there has also been new legislation in relation to Domestic Abuse and also a new Children Act in 2004 and more recently the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act, 2015. From the panel's point of view, and as far as the DHR is concerned, the most important conclusion from this section of the DHR was that all workers, from every discipline, should be certain to exercise 'professional curiosity' and carefully risk assess the ability of a victim of Domestic Abuse to protect children, especially when the abuse is severe and there is no clear evidence that a relationship is ended.

7.3. The panel concluded that the timescale of involvement of SSD with the family in Wrexham was very short given the situation and the seriousness of the assaults reported.

It could be argued there was insufficient time to test out the plan, which was put in place with the family. The Social Worker was optimistic about the parents' cooperation, however the grooming and control of the offender was seminal to any full assessment of risk, and this element of the assessment of risk is not fully apparent. With the value of hindsight we found that P1 was still very much part of the life of V3 at the time the case was active in Wrexham. We now know that the children, both the subject child and her siblings and P1's children stayed at the family home when P1 was present against the terms of the protection plan, though we have no evidence that this occurred before Social Services closed the case, or whilst the couple lived in Wrexham. We do know that the children had staying access and were left in the care of P1 whilst the mother worked and after the couple had moved to Flintshire and P1 and V3 had married.

7.4. So, the Panel wish to emphasise that practitioners should be careful to consider all children who may be in regular contact with a violent person and not only those who are permanently resident in a household, where there is domestic abuse, as there may be children who have regular 'staying contact'. The Panel is in agreement with Wrexham Social Services Department's conclusion that practice has changed since 2001 and we agree about the importance of the use of genograms and thorough information sharing between agencies; but in child protection cases this information should also be shared between counties when families move. We know that not all the children in this matter resided in Wrexham or Flintshire. Domestic Abusers may well have children from previous relationships and they too should be considered when assessments are made and their parent/carer should be informed of any risk to them as a result of any new investigations.

7.5. The Panel also made the observation that risk assessment tools are now used in Domestic Abuse cases and these are of course very useful but they are no substitute for 'Confident Competent Practitioners' who take into account all the information available and are also alert to an offenders' attempts to groom and control environments and workers, as well as their victims.

8. The second additional area explored by the DHR Panel

Verbal Threats against V2

8.1. The second period the panel considered, involved V2 who was P1's first wife. V2's relationship with P1 also preceded the timescale of the review. However, when V2 was interviewed by North Wales Police following Marie's death, she stated that very serious verbal threats continued to be made towards her, many years after her divorce from P1, and some of these threats fell within the DHR timescale.

8.2. V2 married P1 and lived in RAF accommodation with him at the start of the 1990s. The author interviewed V2 for the purpose of this review and she explained how she had suffered a severe level of violence, which began straight after her marriage to P1 and

whilst he was serving in the RAF as an RAF police dog handler. Having heard V2's story one of our aims was to ensure that the level of violence that V2 reported and which is alleged to have taken place on RAF premises, would result in more proactive action and protection for victims than it had in the past.

8.3. We found that there is no national protocol/arrangement for how the Armed Services and Civilian Police respond to and manage Domestic Abuse incidents relating to service personnel or their families; or to Domestic Abuse incidents which take place on Ministry of Defence property. Therefore, the panel thought it appropriate that a recommendation is made that a protocol is developed for North Wales between any Military Forces based here, currently this would be the RAF, and the North Wales Police. Panel also recommend to the Home Office that such protocols should be a national requirement as this would provide consistency of response.

8.4. Moving evidence was given to the DHR by V2 about how she suffered and yet was not listened to by agencies in the past, especially when she lived abroad on an RAF base. There was also evidence from her that that practice issues about attitudes and approaches to victims need to be followed up in training. These practice issues are about the need to be sensitive to victims when they contact services at any level, from the receptionist or call handler, to the police officer or court official. To do this, all staff should keep at the forefront of their own minds the courage victims need to find, in order to make contact with services and the fear they have of doing so. Not forgetting that violence and control may well increase if the perpetrator becomes aware of the contact.

8.5. V2 told us about a call she made when she became aware, through her own children, of the fact that the children of V3 were not allowed to stay with V3 if P1 was present. V2 said being concerned about the safety of her children she contacted the police and social services. The panel are of the opinion that when V2 did this she was not given sufficient information with which to protect her children. So the panel concluded that parents and carers should always be given enough information to assist them in protecting their children when they make enquiries due to concern about the risk an abusive person may present. So, panel have recommended that workers are given sufficient training support and guidance to enable them to be confident about what information they can give. The guidance and training should also direct workers to the statutory avenues now available regarding information sharing such as the CSODS and DVDS

8.6. We wish to note that we learned a great deal from speaking to victims about the lasting impact of trauma on families who suffer domestic abuse and the difficulties still inherent in seeking help.

9. The third area of the second part of the DHR concerned the only criminal conviction of P1.

9.1. The review found that there was an incident, which took place at the end of 2006 and for which P1 was convicted and sentenced in 2007.

9.2. P1 met V4 after his relationship with his second wife, V3, ended. P1 was working locally in Flintshire and he moved in with V4. They were introduced by mutual friends. V4 told us that she was not only assaulted at home but also, like some other women P1 met, at a scooter rally. V4 said that the children were in the house when the assaults at home took place. They would be upstairs and were told not to come down if anything happened. However, sometimes assaults would spill into the children's rooms. In fact it was one of the children who called the police after the assault, which took place in the early hours of the 19th December 2006; the police had already been called by V4 late on the evening of the 18th December 2006 and had already visited the house.

9.3. We found that there were failings in 2006/7 and these are summarised below:

- **Whilst we acknowledge the independence of courts, we hope that courts can also benefit from the learning in DHRs. We found that the court did not, it appears, follow Probation's recommendation in 2006, which means an opportunity to address the offender's behaviour through mandating that he attend the IDAP course was missed.**
- **Poor recording practice was evident in Social Services records.**
- **A lack of support to and communication with the victim by agencies, particularly face to face, led to a missed opportunity to discover that the order made by the court, which prohibited P1's contact with V3, had been breached.**
- **A failure by the social worker to carry out the home visit recommended by the Domestic Abuse panel and her supervisor to assess the risk to the children.**
- **Lack of any follow up support to the children or face to face assessment of the risk to them and to P1's birth children, who were sometimes present at V3's home.**
- **It appears that in 2006 there was some knowledge of the assaults which took place previously in Wrexham. However, it is not clear whether this was passed on in any way which would have assisted the assessment of risk by Social Services and the Domestic Abuse Panel.**

9.4. Panel noted that there is, from December 2015, a remedy in law which did not exist throughout the period when P1 was apparently abusive and controlling of a number of women. The panel also notes that a national advertising campaign is, at the time of writing the report, raising awareness about 'Coercive Control', which should be a core

element of all training across the multi-disciplinary network in North Wales and elsewhere.

9.5. The new 'Violence against Women, Domestic Abuse & Sexual Violence (Wales) Act' 2015, requires that the Welsh Government National Training Framework be embedded across Wales. This multi-level training framework will ensure availability of quality and consistent training across all public services, which is aimed at raising awareness of Gender Based Violence, Domestic Abuse and Sexual Violence, changing attitudes and improving the nature and quality of support provided to victims. The police though are not included in this requirement for training, so we have recommended that local police forces will need to ensure their PVPU officers access it, as is commensurate with their duties.

9.6. The panel notes that the assault carried out in 2006 and described by V3, illustrates the importance of the role of the IDVA. It also illustrates the importance of face to face assessment of risk to children and of communication with victims; including the nature of that communication, which needs to be sensitive to the level of fear and trauma suffered.

9.7. Lastly it was clear from our interview with V4 that P1 was known to be violent by a number of people and that neither neighbours nor friends reported their concerns to any agency. At the time of writing this review it seems the reluctance to report concerns about domestic abuse is a strong as ever, despite national awareness of Domestic Abuse and the continuing development of responses to it and despite the level of public access that now exists to reporting helplines.

9.8. Given the length of time since P1's conviction in 2007 the Panel notes there are a series of improvements that have already been made by the agencies but there are also additional recommendations from the National Probation Service and Flintshire County Council Social Services as a result of the findings of the DHR and these recommendations and action plans are attached to the DHR. In addition to the recommendations made by the agencies, the panel also made recommendations and these follow this summary.

9.9. National Probation Service

9.9. 1. The NPS recommended that offender managers should ensure they undertake multi-agency checks at key stages of supervision and review. So, Probation Offender Managers have been reminded of the importance of making checks with relevant agency colleagues at key stages of review; the outcome being improved risk assessment and management of cases informed by multi-agency information

9.9.2. NPS also recommended that Offender managers should ensure regular contact with cases with non-supervisory requirements. So, Offender Managers have been reminded of the importance of ensuring that interviews are arranged with cases at key stages of

sentence plan review, to ensure assessments are current and reflect the circumstances of the case.

9.10. Flintshire Social Services Department

9.10.1. Flintshire Social Services recommended that it was important to incorporate the impact of domestic violence on children and young people into the Social Services' single assessment document and assessment process, so that children and young people's needs are identified and appropriate support provided.

9.10.2. Flintshire also recommended that their procedures for domestic violence are reviewed and updated to cover:

- **Standard referral processes to MARAC where there are 14 or more risks identified in the 'Safer Lives Tool' or there are significant professional concerns**
- **The requirements for PNC checks for DV cases**
- **Active consideration of the network of contact that perpetrators of domestic violence have with children and young people and the need to notify/share information for their safety**

9.10.3. The third recommendation that Flintshire made was about case recording guidance which needed review and updating to ensure that there are clearly articulated standards for appropriate case recording.

9.10.4. Work has already begun on Flintshire's recommendations as can be seen in the action plan.

10. The fourth area explored by the DHR Panel

10.1. There was an incident, which occurred at a Royal British Legion Bikers Rally in Wales, in July 2013, which resulted in the need for the victim's hospital attendance.

10.2. The assault on V5 took place in July 2013, and as described by her, is consistent with the other reports about the behaviour of P1. These reports were made to the police after Marie's death by women who do not know each other and are not in contact with each other. V5 described the assault as a very forceful open handed slap to the head, that she said "was maximum impact, least visible damage," a description that fits entirely with the statement made to the report author by V4. At the time of the assault P1 had again been drinking and indeed alcohol is said to be a frequent factor when P1 attacked his partners, though the report author has been told that this was not always the case. When he was interviewed for the purpose of this DHR by a panel member and the report author; P1 denied the level of this assault, and his responsibility for it.

10.3. This assault was very upsetting, frightening and indeed traumatising for the victim and her daughter. Those who were in contact with her at the time of the assault failed to assess the level of impact and seriousness of the abuse. The trauma has had a long lasting impact on V5 and her daughter.

10.4. Aneurin Bevan University Health Board

The Health Board responsible for the hospital that V5 visited are ABUHB and they acknowledged that processes which were in place in the hospital at the time of V5's attendance were not followed. In the intervening time, Domestic Abuse Training has been provided to staff and a dedicated Domestic Abuse ABUHB web based site has been established for staff as a resource and as part of an awareness raising campaign. Going forward recommendations, which were made by ABUHB, will focus upon the 'Ask and Act' guidance across the organisation. Outcomes will be monitored through the Health Board procedures and the Regional statutory Violence against Women, Domestic Abuse and Sexual Violence Board, on which ABUHB has senior representation.

10.5. These recommendations were;

10.5.1. Recommendation 1: To increase the identification of those experiencing violence against women, domestic abuse and sexual violence and to offer timely referrals and interventions for those identified as at risk. [This guidance also addresses the direct link between domestic abuse and child maltreatment]

Aneurin Bevan University Health Board must ensure that the targeted enquiry under the statutory guidance 'Act and Act'; is implemented across the organisation.

10.5.2. Recommendation 2: Aneurin Bevan University Health Board works to the All Wales Child Protection Procedures [2008]. To remind frontline staff to consider the risk to children and the need to make a child protection referral, when a parent or close relative is identified as experiencing violence against women, domestic abuse and sexual violence.

10.6. The Royal British Legion

10.6.1. The rally organisers, who are volunteers, did to some extent deal with the situation following the assault; they took V5 to the hospital and the next day to the train station and they separated P1 from her. However, panel concluded that there was a failure to appreciate the seriousness of such violence and from what we have been told during this DHR, P1s behaviour was known to members of the TRBL Bikers Group prior to July 2013.

10.6.2. TRBL is a much respected, indeed revered organisation in British Life, the DHR Panel concluded that as such, TRBL need to ensure that their organisation, at every level, has a zero tolerance of Domestic Abuse and follows procedures laid down by the organisation.

10.6.3. Panel have recommended that TRBL develop a specific policy and procedure in order to manage such incidents and that their mission statement in TRBL Safeguarding policies contains a statement of zero tolerance of Domestic Abuse.

10.6.4. TRBL also need to ensure that the organisation does not appear to condone such abusive behaviour by allowing anyone to remain in any kind of role, which appears to give them authority, once a member has offended in this way.

10.6.5. The Royal British Legion has written to panel stating that they accept these recommendations.

10.6.6. The CSP Board recommended that WCVA and NCVO provide guidance for all Voluntary Organisations, which ensures a robust standard for Child and Adult Protection Procedures within Voluntary Organisations and provides procedures for reporting Domestic Abuse. The guidance should make a statement about nil tolerance of Domestic Abuse. Guidance should also be provided for voluntary organisations about participation in DHRs and other serious case reviews.

11. Learning about the behaviour of the offender from Victims

11.1. Given the commitment of members of the public to the production of this Domestic Homicide Review we felt that the Executive Summary should contain a summary of learning from the interviews with women and the statements made available to the DHR.

11.2. Hiding Offences in plain sight

As a panel we were told how P1 habitually told the women he met and also at times workers he met, about his past offending behaviour, which he minimised. This meant that people felt he was being open and honest with them. This tendency of P1 to self-revelation led to the people around him thinking that his behaviour was explicable and that he was changing, or would change. We found during this DHR that there is still a tendency for people to "Take people as they find them". In the case of those who commit serious abuse of their partners, this is a dangerous stance for potential partners to take. The panel concludes that there should be more emphasis in Domestic Abuse literature and advertising on how victims are groomed and controlled, because P1's tendency to hide his violent behaviour in plain sight; was a common theme evidenced throughout this review and no doubt part of his grooming technique.

11.3. Alcohol Use, Abuse and Violent Behaviour

Unsurprisingly, we found that P1 had often been drinking before he was physically abusive. P1 recognised, during the interview with him, the risk of his behaviour re-occurring if he was in a 'drinking' situation. However, it should be noted that he was described as possessive and controlling to an extent which amounts to coercive control, even when he had not been drinking. Several of the women used the expression of

walking on eggshells, because it was not possible to know what would trigger P1 to lose his temper.

11.4. Minimising Offences

As stated above P1 did not hide his past, he talked openly about it. This had the effect of women knowing about his past before anyone else told them; therefore they thought he was being honest, open and reformed. P1 made well controlled and almost disguised, disparaging remarks about victims when interviewed for this DHR. Whilst he did not go as far as to say assaults were their fault, he nevertheless made sufficient mention of their characteristics so as to hint that they were not all innocent victims. In this he totally minimised his own responsibility for his behaviour. He was able though to admit he was a big man and that a victim would be very afraid of him. He made no attempt to diminish his responsibility for the murder of Marie.

11.5. Assaults on parts of body where injury is less evident

The pattern of assault described to us was fairly consistent, with the head being usually the target. This would often mean that injuries were hidden by hair. Several women commented to us that they were hit "like *he'd done it before*". Other injuries were in areas more likely to be clothed and so we conclude that practitioners should be extremely wary of making assumptions when they do not immediately observe physical injury, when they are attending Domestic Abuse situations, or dealing with victims of abuse.

11.6. Calls late at night

Whether or not P1 consciously knew that late at night the resistance of people is lower or that they are more fearful, we don't know. We do know that the women were often contacted late at night and that they were less able to either cope with his threats or resist his demands. This is part of the grooming and control process. It is now recognised that people are checking their phones at all hours and take tablet devices and phones to bed. One way of reducing the threat from abusive and controlling behaviour is simply to reduce the possibility of late night contact by having a social media and phone curfew and so only answering devices when rested and when other people and agencies are more easily contactable.

11.7. Access to help lines

Whilst on the subject of phones, we perceive there to be increased reliance on support being offered via phone helplines. It is therefore important to note that some victims feel that using such support may not be possible due to coercive control being exercised over their lives and also a preference for face to face contact for instance from a drop in centre. So there is certainly a need for other forms of support.

11.8. Seeking help

11.8.1. Much of what we have heard from victims is about how hard it still is to seek and use help, (including medical help for injuries), to report offending behaviour and to recover from being groomed, controlled and assaulted. We heard how hard it is to realise what is actually happening to you as a victim, especially if you are normally a strong competent woman running a family and with a working life. The women we spoke to said they had the feeling that 'this simply does not happen to people like me'.

11.8.2. We heard from their mothers how children are traumatised by Domestic Abuse and how they so often suffer from hearing or seeing abuse and in one case being directly physically assaulted. We heard how children try to move on by not talking about what happened.

11.9. Reporting by neighbours, friends, family and the General Public

Of significant importance is encouraging reporting by victims, friends, neighbours and relatives, when they know abuse is occurring. People need supporting and protecting when they come forward. It was clear to us that in spite of all the progress made in managing cases of Domestic Abuse we still have a long way to go, in order that victims feel safe enough not only to report abuse but also to go through with a prosecution. The same applies to the 'post reporting stage', in terms of victims feeling able to access suitable help for their physical and emotional injuries.

11.10. Quality of Practice

In many ways our findings on balance are much more about quality of practice than about procedure. We heard from the Victims we spoke to how important every step of dealing with them is and how that is about empathy and receptiveness, from the very first stage. This applies from the point at which victims contact reception staff, to contact with professionals who see people in A and E or a GP surgery and extends to contact with volunteers. Personal engagement and a listening approach, without doubt makes a difference as to how able victims are to proceed to disclosure. Post disclosure support also matters because of the evidence that trauma is very hard to recover from. Therefore, the DHR Panel have made a series of recommendations about training of staff, with an emphasis on a listening empathic approach to dealing with Victims.

13. Recommendations and assigned responsibility

RECOMMENDATIONS

Recommendation 1: Mobile Phones and Calls for Help: Recommendation for Regional Domestic Abuse Advisor and National Recommendation for Welsh Assembly and Home Office, to be monitored and progressed locally by the Safer Communities Board

11.23: Where a person had dialled 999 from their mobile phone then unless they provide details of the nature of the emergency situation and give details of their location information to the BT Emergency Call Handler help is not guaranteed to come. This is especially true for those persons who use unregistered 'Pay as You Go' mobile phones. Users of mobile devices are less likely at any rate to be located than those who use landlines.

So:

a) All spoken advice and leaflets nationally and locally should reflect the above.

b) The advice and guidance given on how to seek help in an emergency situation and the pitfalls of relying on silent calls needs to form part of any training or publicity.

c) The Silent Solutions method needs wide ranging and frequent publicity and needs to feature in advice leaflets, procedures and training for all agencies who give advice, or assist victims of Domestic Abuse both locally and nationally.

Recommendation 2: The Risks Inherent in Internet Dating: National Recommendation

We recommend that there is a national information advert about the risks inherent in using internet dating sites and personal disclosure on line. This should include information on how to meet safely, and on recognising the first signs of coercive control and abuse and what to do about that.

Recommendation 3: Advice on Safeguarding whilst using Internet dating sites: Local Recommendation North Wales: Community Safety Partnership.

We recommend that advice on safeguarding whilst using internet dating sites and other social media should be included in those areas to which we already have ready access and can make changes this includes; council safeguarding web sites, domestic abuse advice web sites and leaflets and police advice pages.

Recommendation 4: Training for GPs and Health Workers regarding patient's disclosures that may indicate Domestic Abuse: Local BCUHB and National Recommendation.

We recommend that training is provided to GPs and Health Workers about how to recognise and deal with Domestic Abuse issues that may arise in discussion with their patients, including how to manage disclosures from patients about abuse, which they indicate they may be perpetrating against their partner or family members.

Recommendation 5: National recommendation regarding 'Threshold Guidance' and training for GPs and Health workers regarding patient's disclosures that may indicate

Domestic Abuse. Home Office with Royal College of Physicians and the Royal College of Nursing

We recommend to the Home Office that discussion take place with the Royal College of Physicians and the Royal College of Nursing to ensure that the legal and ethical limits on patient confidentiality are re-considered in terms of Health Professionals being given clear guidance about how to recognise and manage when Domestic Abuse issues arise in discussion with their patients or are indicated by their patient's presentation. This should include how to deal with disclosure from patients about significant anger control issues, which may indicate to a GP or other Health Worker that the patient may be a danger to others, including the patient's partner or children.

Recommendation 6: Protocol between Military and Civilian Police Services: North Wales Police and RAF Valley.

We recommend that a protocol for managing incidents of Domestic Abuse is developed between North Wales Police and RAF Valley.

Recommendation 7: Protocol between Military and Civilian Police Services: National Recommendation to Home Office.

We recommend that nationally consideration is given to developing protocols between civilian police forces and military police services across the British Isles where they do not already exist.

Recommendation 8: The Importance of a listening and empathic approach in all staff contact with victims: North Wales Regional Safeguarding Board.

Panel recommends that supervision and training of staff across the multi-agency network, including training of reception and ancillary staff, emphasises the importance of a listening and empathic approach. This training should ensure that staff keeps at the forefront of their minds the courage that it takes to ask for help or to report abuse.

Recommendation: 9 Awareness of increased danger when victims report abuse: North Wales Regional Safeguarding Board Adult and Children and Regional Training Consortium VAWDASV Strategic Board.

We recommend that staff are trained to recognise that when a person is reporting domestic abuse or planning to leave an abuser that the victim of abuse is likely to be at increased danger if the perpetrator becomes aware of their action or intention.

Recommendation 10: Procedural Guidance on the Disclosure of adequate information to parents so that they can protect their own children: North Wales Regional Safeguarding Board/Adult and Children.

We recommend that all agencies concerned with safeguarding check that their procedures give sufficient guidance to staff to ensure that workers disclose adequate information to

parents and caregivers of children and vulnerable adults in order that parents and carers are able to protect those for whom they care. This guidance should include reference to schemes that are already in place such as the Domestic Violence Disclosure Scheme (Claire's Law) and the Child Sex Offender Disclosure Scheme, which was introduced in order to raise public confidence and increase the protection of children. This disclosure scheme includes routes for managed access to information, regarding not only those individuals who are convicted child sex offenders, but who pose a risk of harm to children. Such persons would include those who have been convicted of serious domestic violence.

Recommendation 11: Training and Supervision relating to disclosure of information to parents: North Wales Regional Safeguarding Board Adults and Children.

We recommend that training and supervision of staff responsible for safeguarding should always include a reminder of their duty to give sufficient information to parents and carers so that vulnerable children and adults are protected.

Recommendation 12: Following up on recommended actions from Supervision by Senior Workers: Flintshire County Council.

Flintshire Social Services should ensure that during the supervision of fieldwork social workers that supervisors carefully record the instructions given to the worker. Supervisors should then check that the instructions have been carried out. Supervisors should note that these tasks have been completed and if not should make sure that they are promptly followed through.

Recommendation 13: Clear Recording of Decisions, and reasons for decisions, in Decision Making Forums: North Wales Safeguarding Boards for Children and Adults

We recommend that agencies should review their recording policies to ensure that all decisions and recommendations from panels, case conferences and other decision making forums are clearly recorded and that the reasons for those decisions are clear in the notes of the meeting.

Recommendation 14: National Recommendations to the Home Office regarding the role of Courts:

Whilst we recognise the independence of the courts and that sentencing guidelines exist we make a national recommendation that Courts consider carefully the opportunities that may be missed to moderate an offender's behaviour if they do not follow the recommendations of the National Probation Service in those cases where it has been identified that it would be appropriate and beneficial for the offender to attend a treatment programme. If the court decides not to follow such a recommendation the reason should be documented.

Recommendation 15: Retention of Court Records: Home Office

We recommend that nationally, court records should be retained for a sufficient period so that any review, such as a serious case review or DHR, can benefit from access to those records. Ten years would be a reasonable timescale.

Recommendation 16: Recommendation from DHR Panel to National Training Consortiums Wales

(*Panel notes that it is already a requirement that all front line staff and managers in Wales will be trained on national minimum standards for implementation of the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015. A Regional Training Consortium will be set up in North Wales for the purpose of rolling out the delivery of Welsh Government National Training Framework and will run for 5 years)*. **The panel recommends that the findings of the DHR are fed to the organisers and trainers in order to ensure that training emphasises that assessments must be robust and dynamic and not over reliant on single tools.**

Recommendation 17: The use of Tools in Domestic Abuse work and The Importance of Assessment: North Wales Regional Training Consortium.

17. a. We recommend that training and supervision focuses upon quality assessments which emphasise the use of professional curiosity and judgement and avoids over reliance on tools.
17.b. Professionals should be trained to recognise that tools are frameworks for the collection of information and to assist in assessment but they are not the complete assessment of risk; which should be a dynamic process involving the collection and evaluation of all the relevant information available including the voices of victims and families. 'Safe Lives' is part of that assessment and not the whole of it; the outcome of the use of the 'Safe Lives' tool should be measured together with all other information available.
17. c. When making an assessment in cases of domestic abuse the focus on the victim should not detract from also gaining sufficient information about the perpetrator to protect those with whom he has or is likely to come into contact. So agencies need to note that 'Safe Lives', which has replaced the 'CAADA DASH' tool, does not cover this area of an assessment currently. Therefore, assessors must ensure they gain sufficient information about a perpetrators circle of contacts to ensure the safety of all other vulnerable contacts is taken into account.

Recommendation 18: Recommendations re: Training to the North Wales Regional Training Consortium

18. a. The Panel recommend that training programmes ensure that practitioners and their managers are careful to consider all the children and young people who may be in regular contact with a violent person and not only those who are permanently resident.
18. b. The training of frontline staff, that attend multi-agency meetings and make assessments in regard to victim safety across the age ranges, should include a section which

covers the grooming and control of workers and of the multi-agency network. This is in recognition that abusers attempt to control environments, including professionals as well as their victims.
18. c. Training on risk assessment in domestic abuse should include reference to the phenomena of hiding offences in plain sight, as this is similar to 'Disguised Compliance' in child protection work and can mislead and falsely reassure practitioners.
18. d. Training needs to help practitioners explore the complexity of working in the area of personal relationships and to raise awareness of the conflicts of loyalty which exist for the victim when reporting abuse or considering ending relationships.

Recommendation 19: Involvement of relevant North Wales Police personnel in the regional training in respect of the implementation of the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015: North Wales Police

Panel notes that the police are not included in the requirement for training regarding the implementation of the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 and so we recommend that Domestic Abuse Officers and PVPU officers in Wales undertake training that is commensurate to their role.

Recommendation 20: TRBL has a zero tolerance approach towards Domestic Abuse.

We recommend that The Royal British Legion has a mission statement in its safeguarding policies which makes it clear that TRBL has a zero tolerance approach towards Domestic Abuse.

Recommendation 21: Managing Partner Based Violence on the premises or at events organised by or on behalf of TRBL

We recommend that TRBL develops a specific policy on managing incidents of Domestic/Partner based violence that occur either on their premises or at events that are organised by or specifically on behalf of TRBL.

Recommendation 22: Holding positions in TRBL when it is known a member has carried out an act of Domestic /Partner Abuse: The Royal British Legion

We recommend that TRBL ensure that all its officials and organisers think very carefully about placing anyone in any position within the organisation, however lowly the role, after they have committed an act of Domestic Abuse at a TRBL event. We say this because doing so not only gives the message that tolerance of such abuse exists within the organisation but it may further assist the ability of the perpetrator to coerce and control others.

Recommendation 23: Recommendation to Welsh Council for Voluntary Action and National Council for Voluntary Organisations regarding the need for clear guidance that ensures adequate standards for protection procedures in voluntary organisations.

We recommend that WCVA and NCVO provide guidance for all Voluntary Organisations, which ensures a robust standard for Child and Adult protection procedures within Voluntary Organisations and provides for procedures for dealing with and reporting Domestic Abuse. The guidance should include a nil tolerance stance to Domestic Abuse. Such guidance should also refer to the various serious case reviews which may take place for instance Child Practice Reviews, Adult Protection Reviews and Domestic Homicide Reviews and the importance of full participation in these reviews when requested.

Recommendation 24: Advice to victims to switch off phones and devices late at night: Community Safety Partnership

We recommend that advice to victims given directly or via leaflets, on line etc. includes advice to switch off phones and devices to avoid being contacted when made vulnerable by tiredness or being awoken from sleep.

Recommendation 25: The importance of a listening approach: Community Safety Partnership and NWRSB.

We recommend that supervision and training across the multi-agency network, including training of ancillary and reception staff, emphasises the importance of a listening approach and aims at ensuring that staff keep in the forefront of their minds the courage it takes to ask for help and to report abuse.

Recommendation 26: Recognising there is a risk of increased danger to victims when reporting abuse: Community Safety Partnership

We recommend that staff are trained to recognise that when reporting domestic abuse or planning to leave an abuser, a victim is likely to be in increased danger if the perpetrator becomes aware of this.

Recommendation 27: Support for Family, Friends, Neighbours and the General Public: Welsh Government Proposed Publicity Campaign:

The panel will request that the Welsh Government publicity campaign regarding Domestic Abuse includes reference to supporting family, friends, neighbours and the general public to report abuse and how they can report.

Recommendation 28: Supporting the public to report Domestic Abuse: National Recommendation: Home Office and Welsh Government.

We recommend that national discussions about further developments aimed at the prevention of Domestic Abuse includes how relatives, neighbours, friends and the general public can be encouraged and supported to report abuse.

Appendix one

FLINTSHIRE DOMESTIC HOMICIDE REVIEW

Terms of Reference

1. Introduction

1.1 This Domestic Homicide Review (DHR) is commissioned by the Flintshire Community Safety Partnership in response to the death of Marie on 14th September, 2014.

1.2 The DHR has been commissioned as the death meets the criteria defined in the statutory guidance issued by the Home Office of an incident involving 'a person to whom he was related or whom he was or had been in an intimate personal relationship' (Home Office 2011:5). This is a statutory requirement under the Domestic Violence, Crime and Victims Act 2004.

2. Chair and Membership

2.1 Jenny Williams, Strategic Director of Social Care and Education Services at Conwy County Borough Council has been appointed as Chair of the review panel. Jenny Williams has had no contact with any family member or any of the women who came forward. She is chair of the regional Safeguarding Children's Board and a member of the National Safeguarding Board.

The following organisations are represented on the panel:

Organisation
Betsi Cadwaladr University Health Board
Conwy County Borough Council
Domestic Abuse Safety Unit
Flintshire County Council
National Probation Service
North Wales Police
North Wales Fire and Rescue Service
Welsh Ambulance Service Trust

3. Purpose of the Domestic Homicide Review Specialist Panel

3.1 Ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

3.2 Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence including their dependent children.

3.3 Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.

3.4 Apply these lessons to service responses including changes to policies and procedures as appropriate and

3.5 Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

3.6 Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

4. Scope of the Review

4.1 The Panel will focus on the period between 1st May 2005 and 14th September 2014.

4.2 Within the scope of the review all significant and relevant contacts made with the deceased (during the time of her relationship with the perpetrator); the perpetrator; and any other identified persons.

4.3 Organisations who have had significant contact with those persons identified in section 4.2 will be requested to participate in the review process, and may be required to complete an Individual Management Review (IMR), as directed by the Panel.

5. Purpose of Individual Management Reviews

5.1 The following areas will be addressed in the Individual Management Reviews and the Overview Report:

5.2 Whether family, friends or colleagues were aware of any abusive behaviour from the alleged perpetrator to the victim, prior to the homicide.

5.3 Whether there were any barriers experienced by the victim or her family/ friends/colleagues in reporting any abuse in Flintshire or elsewhere, including whether she knew how to report domestic abuse should she have wanted to.

5.4 Whether there were opportunities for professionals to 'routinely enquire' as to any domestic abuse experienced by the victim that were missed.

5.5 Whether there were opportunities for agency intervention in relation to domestic abuse regarding the victim or alleged perpetrator that was missed.

5.6 The review should identify any training or awareness raising requirements that are necessary to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

5.7 The review will also give appropriate consideration to any equality and diversity issues that appear pertinent to the victim, alleged perpetrator e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

6. Sharing of Information

6.1 Partners and organisations that have been approached by the Panel to share information should refer to the Home Office's Statutory Guidance on Domestic Homicide Review, should issues regarding consent arise.

6.2 Legal queries regarding information sharing will be addressed by Flintshire County Council's Legal Department, and should also be considered by the legal department of the respective organisations.

7. Publication

7.1 The Panel will follow the guidance set out by the Home Office in respect of publication. It is a requirement that the Overview Report shall belong within the public domain.

7.2 The Panel will identify persons who should have sight of the report and overview report, prior to publication.

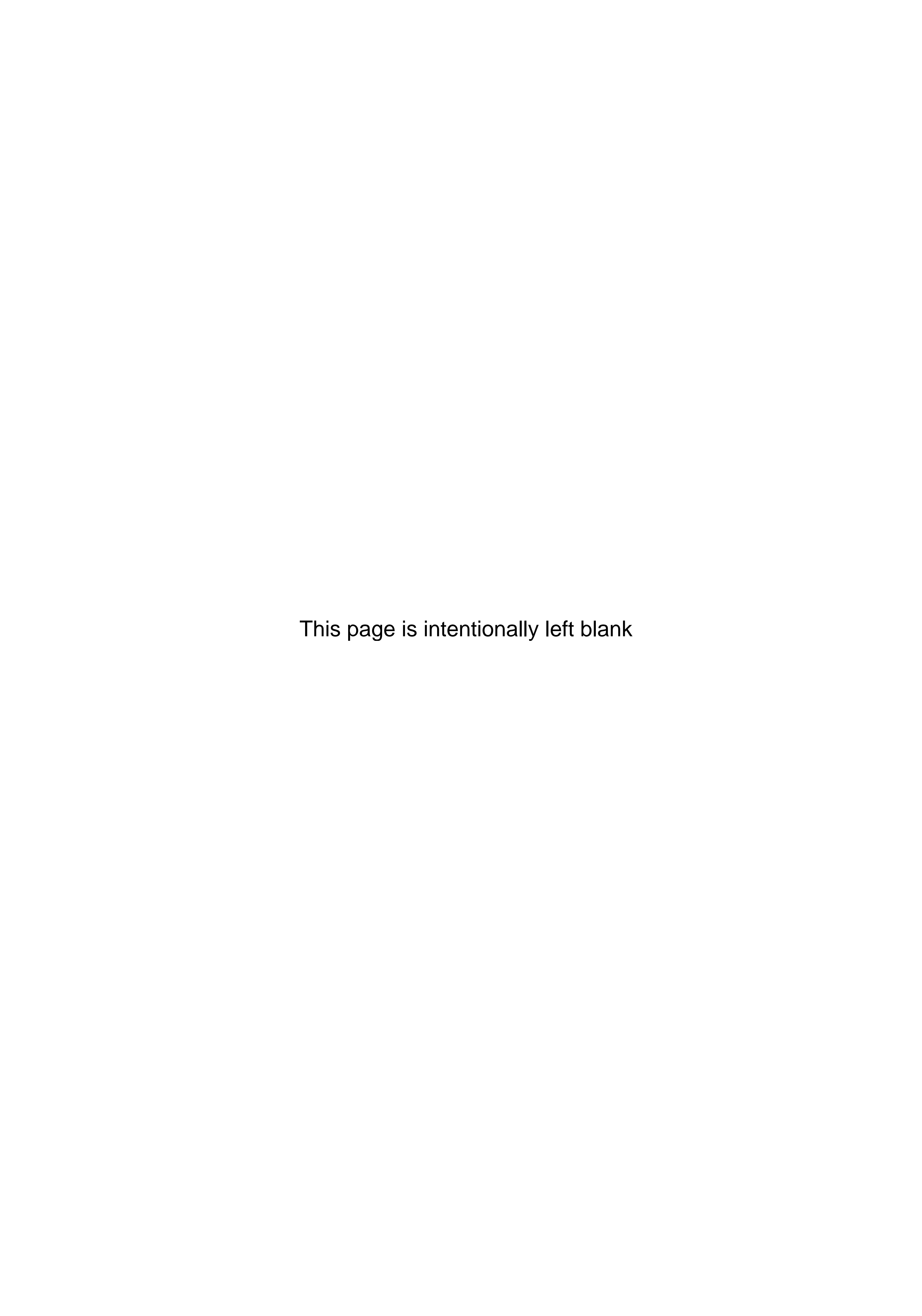
8. Frequency of Meetings

8.1 Meetings will be convened at the direction of Chair. The administration and co-ordination of the Review will be undertaken by Flintshire County

Appendix 2

Acronym	Meaning
ABUHB	Aneurin Bevan University Health Board
A and E	Accident and Emergency
AWCPP	All Wales Child Protection Procedures
BCUHB	Betsi Cadwalader University Health Board
BT	British Telecom
CAADA DASH	Co-ordinated action against Domestic Abuse Stalking and Harassment
CEO	Chief Executive Officer
CFR	Community First Responder
CID16	Criminal Investigation Department reporting system for sharing information with SSD
CPS	Crown Prosecution Service
CSODS	Child Sex Offender Disclosure Scheme
DA	Domestic Abuse
DA Panel	Domestic Abuse Panel
DAO	Domestic Abuse Officer
DHR	Domestic Homicide Review
DVDS	Domestic Violence Disclosure Scheme
GP	General Practitioner
IDAP	Integrated Domestic Abuse Programme
IDVA	Independent Domestic Violence Advisor
IMR	Internal Management Review
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference

NHS	National Health Service
NPS	National Probation Service
NSPCC	National Society for the Prevention of Cruelty to Children
NWP	North Wales Police
OASYS	
PNC	Police National Computer
PTSD	Post-Traumatic Stress Disorder
PVPU	Protection of Vulnerable People’s Unit
P1	ID given to the perpetrator of the victim
RAF	Royal Air Force
RAG	Risk Assessment Grading
Section 47	Shorthand for the requirement to investigate child protection concerns under the Children Act 1989
TRBL	The Royal British Legion
SSD	Social Services Department
WAST	Welsh Ambulance Services NHS Trust
V1, V2, V3, V4, V5	Ex Wives or Ex Partners of P1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SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEEE

Date of Meeting	15th November 2018
Report Subject	Bright Spots Programme
Portfolio Holder	Cabinet Member for Social Services.
Report Author	Chief Officer Social Services
Type of Report	Scrutiny Report

EXECUTIVE SUMMARY

In February – March 2018 all children in care in Flintshire were asked to participate in a survey about their well-being. The survey 'Your Life: Your Care' was developed by Coram Voice and University of Bristol as part of the Bright Spots programme. The survey asked children in care about their life, based on the things that are important to them. The local authority will use the key findings to inform service development and support arrangements for children in care.

RECOMMENDATIONS	
1	Committee review the findings and perspectives of looked after children from the "Your Life, Your Care Flintshire full report" (22.05.2018).
2	Committee endorse the development of a co-produced action plan with our looked after children, which sets out a local authority response to the key recommendations identified in the Bright Spots full report.

REPORT DETAILS

<table>
<tr><th>1.00</th><th>BACKGROUND</th></tr>
<tr><td>1.01</td><td>Bright Spots is a survey designed to measure the subjective well-being of children in care and how they feel about their care. The Children's Commissioner for Wales, and the Welsh Government, offered to fund the survey in six local authorities to establish the value of the Bright Spots programme. Flintshire was successful in our 'expression of interest' to use the survey to establish the experiential views of children and young people who are in the care of Flintshire Care Services.</td></tr>
<tr><td>1.02</td><td>The survey was based on three on-line or paper surveys to capture the views of children / young people aged
• Younger children aged 4-7 years (16 questions)
• Children aged 8-11 years (31 questions)
• Young People of secondary school age 11-18 years (46 questions)</td></tr>
<tr><td>1.03</td><td>The conduct of the survey followed a set format:
• Surveys were conducted in Welsh and English
• Paper or electronic copies were available
• At the time of the survey 171 children / young people were eligible to complete (36% returned)
• Children and young people completed the survey anonymously
• If any identifying information was shared in the survey, these were removed by researchers</td></tr>
<tr><td>1.04</td><td>The survey had the primary objective of:
• Identifying where children appear to be flourishing
• Where things could be improved
• Providing an evidence based analysis of children's experiences and well-being
• To inform service improvements</td></tr>
<tr><td>1.05</td><td>The survey published three documents (See Appendix A,B&C)

• Your Life, Your Care, full report Final
• Your Life, Your Care Flintshire CYP Summaries Final (22.05.2018) (produced for the children / young people)
• Your Life, Your Care staff summary Final

These provide the level of detail according to the audience produced for and enables an age appropriate understanding into the key-lines and outcomes identified. It is imperative to stress these highlighted the experiences of children ranging across their care experience, education, health, emotional well-being, contact with close/extended family, play, leisure, fun,</td></tr>
</table>

	entertainment and access to pets and associated animals.
1.06	Under the respective age categories, the findings were divided according to the age range and the respective findings under the headings 'What was good" and "What was bad". These highlighted the summary experiences of the children and young people and provided the key sources of the local Authority's "We will" response.
1.07	The following sections provide a high level overview of the key findings arising from the survey. Work will be undertaken through our consultation and engagement forum for looked after children, and with foster carers, to develop an informed action plan to learn, and where appropriate extend good practice as well enhancing support in areas for development.
1.08	The survey has identified the following areas that are working particularly well in Flintshire:
1.09	✓ The majority of the youngest children and young people felt safe and settled in their placements.
1.10	✓ The majority of children and young people trusted their carers and 97% thought that their carers were interested in their education.
1.11	✓ Carers are providing sensitive parenting to young people (11-18yrs) – 92% felt their carers noticed how they were feeling, which is unusually high.
1.12	✓ More looked after children and young people were living in a household with a pet in comparison with children living in Wales and compared to other children in care.
1.13	✓ More young people (96%) in Flintshire felt they were being taught life skills compared to young people (86%) in other local authorities.
1.14	✓ School is working well for the youngest children (4-7yrs) –all reported enjoying school.
1.15	Key areas for development/recommendations identified in the report were:
1.16	➢ Explore why children in Flintshire aged 8-11yrs gave more negative responses compared to the other age groups and compared to similarly aged children in other local authorities. As this is a small, defined cohort of children, we will be able to review and develop our understanding of why they have reported low well-being and

	explore with them how we can help improve their feelings and experiences.
1.17	➢ Make sure that reviews of contact arrangements consider the views of all children. The reasons for decisions are explained to children but we need to do more to ensure that they understand the information and that they are given the chance to ask questions about contact.
1.18	➢ When making plans with children and young people, include unstructured opportunities to explore the outdoors such as walking the dog or playing in a park as well as organised activities. We will talk to children, staff and carers about how we can increase these opportunities.
	➢ Ensure that all social workers introduce themselves to children and explain their roles in a child-friendly way. We have examples of information leaflets that have been produced for children that explains the role of a social worker and provides the name and contact number of their social worker. We will be asking children if this information will help support introductions and what else would assist.
1.20	➢ Explain to children what has led to them coming into care and provide opportunities for them to ask questions. The survey highlights the importance of us working with the youngest children (4-7yrs) to help them understand why they were in care. This includes time to help children understand what has happened, and that they are not to blame. We will review our approach to ensuring that this work is an effective partnership between social services, carers, and where appropriate parents and schools.
1.21	➢ Provide opportunities for young people (11-18yrs) to build self-esteem and positive self-image. 26% of young people were unhappy with the way they looked which is a larger proportion than young people (10%) in the general population. This is an area that we will need to work with in partnership with health, schools and youth services to identify realistic action that can be taken to support our young people.
1.22	➢ Consider how young people might be reassured about the support they can expect to receive in the future.

	Through consultation with young people we will establish the type of support and reassurance they are seeking and how we could work to provide this, including communication channels.

2.00	**RESOURCE IMPLICATIONS**
2.01	The local Authority is required to address the experiences of our children and young people by looking at our current services and have the need to shape and adjust our models of care and support.
2.02	That a range of foster carers need to be recruited and approved to offer a diversity of care arrangements.
2.03	The key findings in relation to the learning experiences of children looked after have been shared with education colleagues.
2.04	General welfare and emotional support services are made aware of the findings.

3.00	**CONSULTATIONS REQUIRED / CARRIED OUT**
3.01	The following have been attended and received the survey outcome finding; • Children and young people in Care Groups • The Children's Commissioner for Wales • Children Services Forum (including education and health) • Key members of third party / sector groups • All staff groups within Social Services teams • Care Standards Inspectorate (Wales) • Foster Care Support Groups • Team, Service and Senior Management Groups • Scrutiny Committee (15/11/2018)
3.02	We would welcome any opportunity to promote the key findings to all groups with an investment in the welfare and well-being of children looked after.

4.00	**RISK MANAGEMENT**
4.01	There is an imperative that the local Authority has a duty to enact the key-lines of inquiries and their application into the every-day lives of children and young people in care.
4.02	Failure to deliver will also receive due scrutiny by the Children's Commissioner, Welsh Government, relevant investigatory bodies and necessary localised scrutiny arrangements.

5.00	APPENDICES
5.01	Your life, your care; full report
5.02	Your life, your care; presentation
5.03	Your life, your care; summary

6.00	LIST OF ACCESSIBLE BACKGROUND DOCUMENTS

7.00	GLOSSARY OF TERMS
7.01	**Contact Officer: Peter Robson** **Telephone: 01352 701028** **E-mail: Peter.Robson@flintshire.gov.uk**

Your Life, Your Care:

a survey of the views of looked after children and young people aged 4-18yrs in Flintshire

April 2018

Professor Julie Selwyn and Jon Symonds
University of Bristol

About this research

BACKGROUND

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Bright Spots

This research is part of the Bright Spots programme: a partnership between the University of Bristol and Coram Voice.

The programme was originally developed in England with funding from the Hadley Trust.

Bright Spots in Wales is a pilot with six local authorities funded by the Children's Commissioner for Wales & Welsh Government through the work of the Improving Outcomes for Children Ministerial Advisory Group to measure looked after children's subjective well-being – how they feel about their lives and their care.

- Through the programme we developed the *Bright Spots Well-Being Indicators*, which put children's experience and voices at the heart of how we measure subjective well-being.
- The indicators are measured by the *'Your Life, Your Care' survey* – a tool grounded in research and comparable to national data sets.
- The survey was developed from literature reviews, roundtable discussions with professionals and from focus groups and individual interviews with 140 looked after children and young people living in nine different English local authorities.
- The survey identifies the areas where children appear to be flourishing and where things could be improved, providing an evidence base of children's experience and well-being to inform service improvements.

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Section 1: Summary: Key Findings

Key findings:

KEY FINDINGS

61 children and young people responded the survey: a 36% response rate with boys under-represented.

79% of young people (11-18yrs) thought their lives were getting better.

Young people had trusting relationships with their carers and social workers

More than a third of 11-18yrs had had three or more social workers in the previous year.

Compared to other local authorities

Fewer (65%) young people (11-18yrs) liked school in comparison with young people (73%) in Wales and looked after young people in other Welsh authorities

Young people (19%) in Flintshire felt embarrassed by adults drawing attention to their care status more frequently than young people (14%) in other Welsh local authorities.

All the children (8-11yrs) and 73% of young people (11-18yrs) had contact with at least one parent. Most children and young people wanted longer and more frequent contact with relatives and more information about why contact decisions had been made.

KEY FINDINGS

Key findings:

There were gender differences in responses from young people (11-18yrs).

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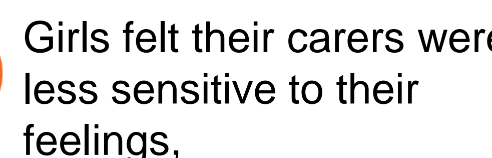
In comparison with girls, fewer boys reported being able to access the Internet outside school;

more boys found their social workers difficult to get hold of and felt excluded from social work decision-making.

More girls worried about their feelings or behaviours than did boys.



Girls felt their carers were less sensitive to their feelings,

4-7 year olds

The majority (62%) of younger children (4-7yrs) did not understand why they were in care.

Half of this age group did not know who their social worker was

Key findings:

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Two of the ten children aged 4-7yrs gave responses that suggested they had low well-being. The children did not understand why they were in care, wanted more family contact, and had poorer relationships with adults and peers.

The two children in the 8-11yrs group with low well-being disliked school, were afraid of bullying and had poor relationships with their social workers.

Nine of the 33 young people (11-18yrs) had low well-being. These young people were more likely to not feel safe or settled in placements, not have a good friend, not like their appearance and lack trusting relationships with carers and social workers

There were only 18 responses from the 8-11yrs age group but they were the least settled in their placements. Only 50% thought their lives were improving and four (22%) felt they were unable to explore nature and the outdoors in comparison with 11% of Welsh children.

Although half of young people (11-18yrs) had high well-being in all areas, more looked after young people were dissatisfied with their lives and not as happy or optimistic about their futures as other young people living in Wales. The survey results suggest about a quarter of the young people need to have targeted interventions that focus on improving relationships (with carers, social workers and friends).

Section 2: Methodology

Methodology

- Three online surveys were used to capture looked after children and young people's views on their own well-being. The three versions were for:
  a) younger children aged 4-7yrs (16 questions);
  b) children aged 8-11yrs in primary school (31 questions); and
  c) young people of secondary school age 11-18yrs (46 questions).
- There was a common set of 16 core questions.
- Surveys were available in English and Welsh.
- Paper surveys were also available and used in cases where no Internet connection was available, or when the child preferred this method.
- In Flintshire, at the time of the survey, 171 children and young people aged 4-18 were looked after and able to complete the survey.
- Children and young people completed the survey anonymously: individual identifiers such as name, school etc. were not collected in order to allow responses without fear of consequences.
- If children recorded names or any identifying information on the survey these were removed by the researchers.

METHODOLOGY

Methodology

- The survey was distributed through the Interim Chief Officer for Education and Youth to Head Teachers and Additional Learning Needs Coordinators (ALNCos) in schools, and to other residential educational settings by email and letter. Regular email reminders were sent and some schools were followed up directly through phone calls.
- The Senior Manager for Children and Workforce within Social Services asked Team Managers and Social Workers to encourage children and young people to complete the survey. Letters were also sent out to foster carers to encourage children and young people to take part.
- Independent Reviewing Officers were encouraged to introduce the survey to young people at review meetings.
- In the final week, a small project team followed up contacts in schools.
- Most children and young people were asked to complete the online survey in school over a four week period from February- March 2018 and, where appropriate, with a trusted adult present. The trusted adult was usually a teacher, learning mentor or ALNCo. A small number of surveys were filled in on hard copy and entered on to the online survey.

Methodology

Subjective well-being: Are children flourishing?

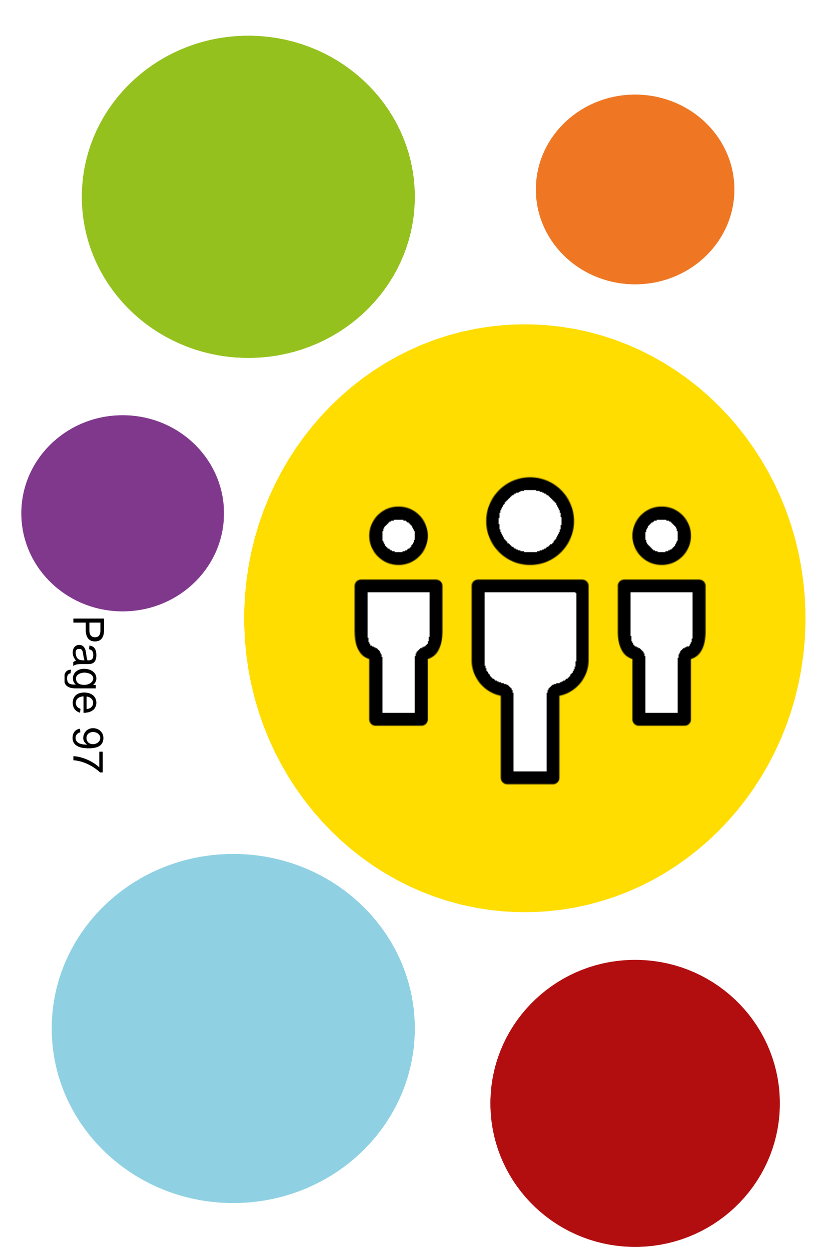
- Subjective well-being in this survey refers to children's own evaluations of how they feel about their lives.
- There are questions in the surveys about affect (e.g. how happy a child feels now), cognitive judgements (e.g. evaluations of relationships) and the inner world (e.g. life having meaning).
- All these elements help us understand whether children are flourishing.

- Where possible, LA data are compared to data on children in the general population, and to the average responses from 5 other Welsh local authorities.
- Data were weighted and tests run for significant difference between LAs.
- In addition to questions that measure overarching well-being indicators (happiness, life satisfaction etc.) the questions cover four domains that are important to children and young people: Relationships, Resilience, Rights and Recovery. The report covers each of these.

On some pages of this report you will see a **'Bright Spots'** icon (shown left). This indicates a 'good news' story – a positive aspect of practice in your local authority.

This is where children and young people are doing significantly better than children in care in other local authorities or report the same or higher well-being than their peers in the general population.

Section 3:
Survey results



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1. Demographics

- Sample sizes
- Age and gender
- Ethnicity
- Placements
- Length of time in care

DEMOGRAPHICS

Sample sizes

Although the sample size must be borne in mind when considering the representativeness of the data, the response rate was significantly better than in some similar surveys. *The State of the Nation: Children in Care, 2015* for example, had a response rate of 3%.

- 61 children and young people completed the surveys from an eligible looked after population of 171.
- The overall response rate was 36%.

Age	**Care population *n***	**Responses *n***	**Response rate %**
4-7yrs	40	10	(25%)
8-11yrs	35	18	(51%)
11-18yrs	96	33	(34%)

DEMOGRAPHICS

Age and gender

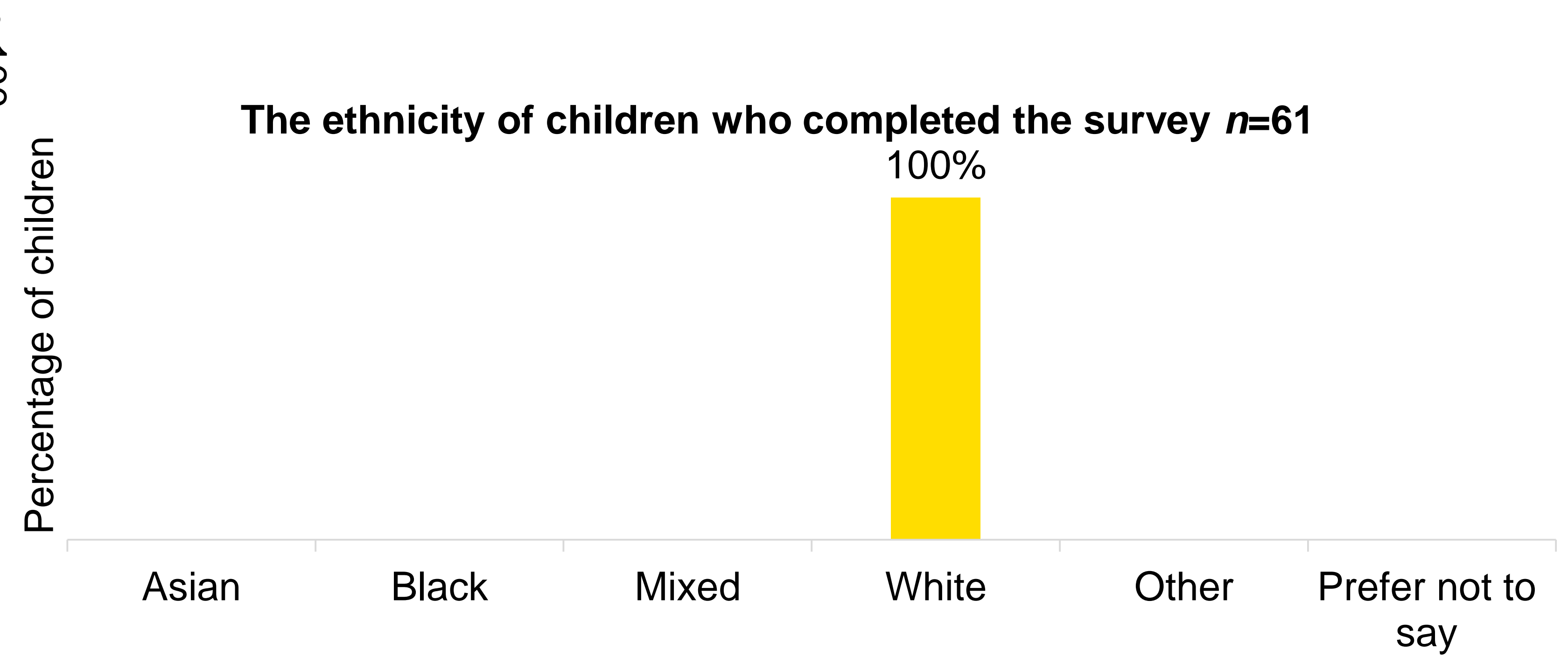
- In Flintshire, 54% of the looked after population were boys (StatWales 2017). Therefore, boys are slightly under-represented in the survey responses.

Age group	Girls *n* (%)	Boys *n* (%)	Prefer not to say/no reply *n* (%)
4-7yrs	5 (50%)	5 (50%)	
8-11yrs	9 (50%)	8 (44%)	1 (6%)
11-18yrs	18 (54.5%)	15 (45.5%)	
TOTAL	**32 (52%)**	**28 (46%)**	**1 (2%)**

Ethnicity

All the looked after children in Flintshire were recorded in the StatWales (2017) database as being of white ethnicity.

- All the children and young people who responded to the survey described themselves as being of white ethnicity, which is consistent with official data.



DEMOGRAPHICS

DEMOGRAPHICS

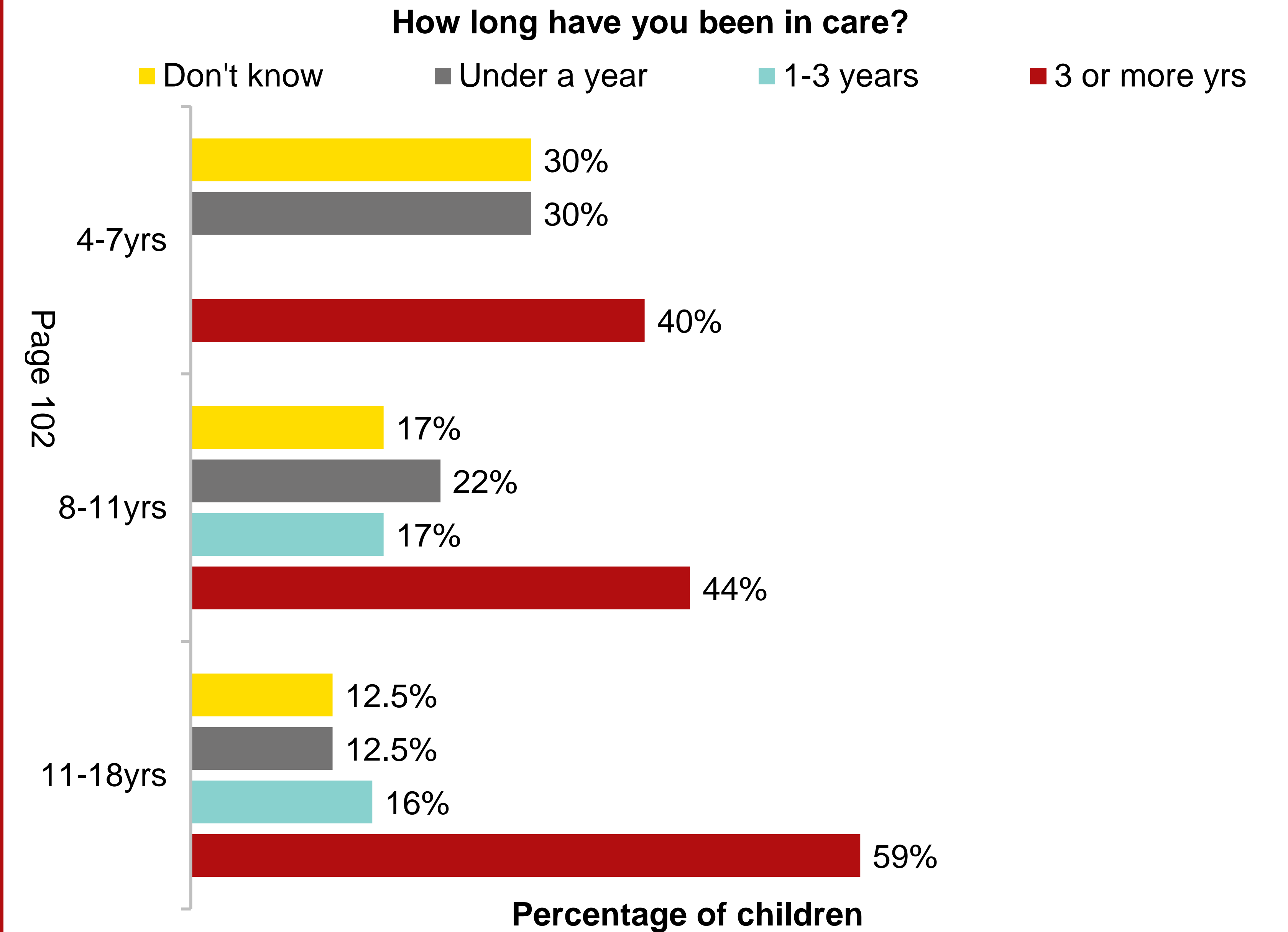
Placements

Children and young people placed with parents were over-represented in the survey responses: 23% of responses compared to the 17% recorded in StatWales 2017.

The majority (44%) of older young people were living in foster care. But younger children who responded were more likely to be in kinship care.

Age group	Foster care %	Family or friends care %	Residential care %	With parents %	Somewhere else %	Prefer not to say %
4-7yrs	20%	60%		20%		
8-11yrs	28%	55%		17%		
11-18yrs	44%	16%	12%	25%	3%	2%
TOTAL	**33%**	**34%**	**6%**	**23%**	**2%**	**2%**

Length of time in care



DEMOGRAPHICS

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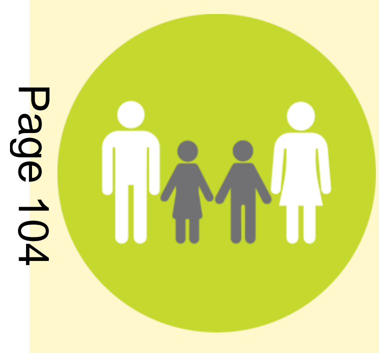
2. Relationships

- Family contact
- Good friends
- Pets
- Adults you live with: Continuity and trust
- Social worker: Continuity and trust

RELATIONSHIPS

Family contact

The youngest children (4-7yrs) were not asked questions about family contact, as it was thought that they might become distressed or anxious.



Children and young people (8-18yrs) were asked whether they were *content with the frequency of contact that was taking place with their mother, father, and siblings*.

I would like to see my mum more than once a month.
8-11yrs

- All the children aged 8-11yrs had contact with their mother.
- 9 (30%) young people (11-18yrs) had no face to face contact with either parent.
- Most of the comments from children and young people asked for more time with their birth family. They also wanted more information on family members who they were not seeing.
- There were a few negative comments on contact centres not providing a good experience.
- Younger children were more satisfied with the frequency of contact than older young people.

RELATIONSHIPS

Family contact

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Family member	Age group	Too much	Just right	Too little	I am unable to see them	Don't have any siblings
Mother	8-11yrs *n*= 17	3 (18%)	9 (53%)	5 (29%)		-------
	11-18yrs *n*=30	2 (7%)	7 (23%)	9 (30%)	12 (40%)	-------
Father	8-11yrs *n*=16	1 (6%)	4 (25%)	4 (25%)	7 (44%)	-------
	11-18yrs *n*= 30		8 (27%)	6 (20%)	16 (53%)	-------
Siblings	8-11yrs *n*=17	4 (23%)	11 (65%)	-	1 (6%)	1 (6%)
	11-18yrs *n*=28	4 (14.3%)	10 (35.7%)	12 (42.9%)	1 (3.6%)	1 (3.6%)

RELATIONSHIPS

Family contact: 8-11yrs

Children were also given the option of providing *comments about contact*.

- Seven children took the opportunity to write their thoughts and feelings about contact. Example quotes are shown below.

Page 106

Don't want to see dad because I don't like him.

I would like to have more time with my mum.

I miss my big brother and sister who are in [place].

Really, really a lot, I see them all Saturdays.

I get to talk to my Mum every single day but my little sister doesn't talk to me that much.

I would like to have contact in different places instead of the same place … The place we go to is boring and there is not much to do.

RELATIONSHIPS

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Family contact: 11-18yrs

- Nine young people took the opportunity to write their thoughts and feelings about contact. The majority wanted more contact with family members.

I would like to see them more.

I don't have a lot of contact with my birth family and I think that there should be more.

I don't have any contact with them but that's because they don't want it.

When I was little my dad went to the army and I don't know if he is still alive and I haven't seen my mum in about 3/4 years.

There should be more contact hours.

Want more.

I would like to see my sisters more please.

I would like to live with my mum.

I wish I could have contact with my adopted brother and sister.

Good friends

A lack of friendships is associated with loneliness and anxiety. All children and young people were asked whether they *had a really good friend*.

General population: *The Millennium Cohort Study (2015)* of young people aged 14yrs found that 3% of young people did not have a good friend.

- Most of the children and young people stated that they had at least one good friend but 4 (7%) did not.
- Being friendless increases the risk of these four children and young people developing depression and anxiety (Hawkley et al., 2010; Criss et al., 2002)

Age group	Yes I have a really good friend *n* (%)	No, I don't have a really good friend *n* (%)
4-7yrs	9 (90%)	1 (10%)
8-11yrs	16 (94%)	1 (6%)
11-18yrs	25 (93%)	2 (7%)
TOTAL	**50 (93%)**	**4 (7%)**

Pets

bright spots

Pets were important to children in all the focus groups we ran.

Children and young people aged between 8-18yrs were asked if they *had a pet in the home they lived in*.

Focus group feedback
Children and young people said that pets are non-judgmental – they love you no matter what and are always pleased to see you. They can also give children an opportunity to take responsibility.

General population
In Wales, 66% of households with a child (under the age of 19yrs), have a pet.

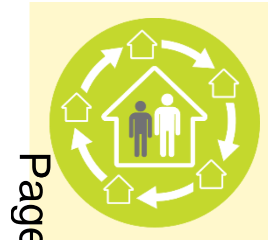
- Ten children (8-11yrs) lived in a household with a pet. Six more answered they would have liked a pet.
- In the 11-18yrs age group, 31 (94%) young people had a pet where they lived. Two young people expressed a wish for a pet.

- In Flintshire more looked after children and young people had a pet in comparison with other looked after children in Wales (average 66% with a pet) and compared to children in the general population (average 66% with a pet). This is a Bright Spot of practice.

RELATIONSHIPS

Adults you live with: Continuity & trust

Placement moves



Young people (11-18yrs) were asked, *how many placements have you had since coming into care?*

Number of placements	Percentage
1 placement	33%
2-4 placements	39%
5-7 placements	3%
8-10 placements	3%
11+placements	3%
Don't know	19%

Trust

Children and young people were asked whether they *trusted the adults they lived with (i.e. carers, parents).*

Positive responses

- 100% of younger children (4-7yrs);
- 94% of those aged 8-11yrs; and
- 100% of young people (11-18yrs) who responded to the question trusted their carers.

- Children and young people reported trusting relationships with their carers. This is a Bright Spot of practice.

RELATIONSHIPS

Social worker: Continuity & trust

Changes in social workers

11-18 year olds were asked, *how many social workers have you had in the past 12 months?*

A larger proportion (37%) of young people in Flintshire reported being allocated 3+ social workers in the year in comparison with other looked after young people (25% with 3+ social workers).

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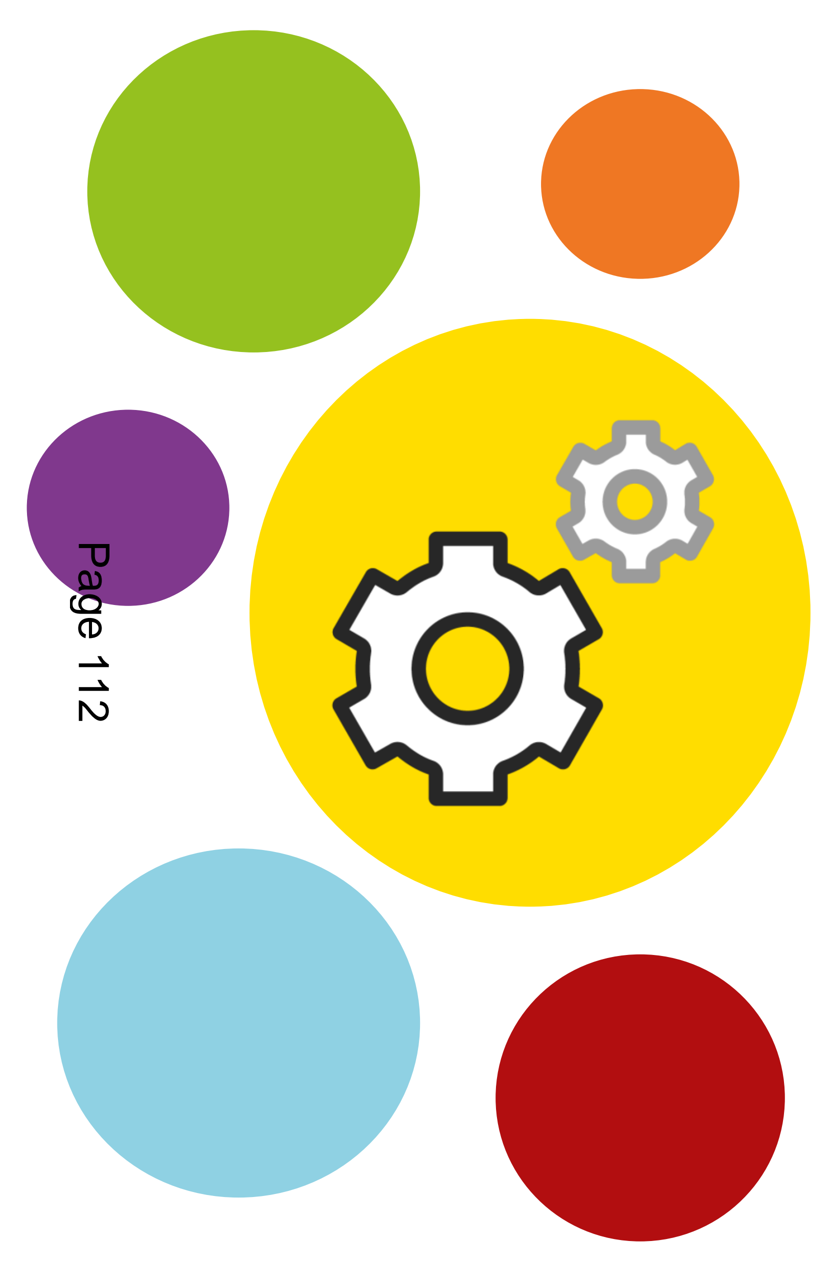
How many social workers have you had in the last 12 months?

	None	One	Two	Three or more
%		25%	37.5%	37.5%

Trusting social worker

Children and young people (n=40) who knew who their social worker was, were asked whether they *trusted their social worker*.

- 80% of the youngest children (4-7yrs);
- 85% of children aged 8-11yrs; and
- 78% of young people (11-18yrs) who responded trusted their social worker.
- Unsurprisingly, trust in social workers was affected by frequent changes of worker.



3. Resilience

- Trusted adult
- Being trusted & helping out
- Liking school
- Adults you live with: Support for learning
- Having fun & hobbies
- Access to nature
- Second chances
- Life skills
- Access to Internet at home

Trusted adult

Children and young people aged between 8-18yrs were asked, *do you have an adult who you trust, who helps you and sticks by you no matter what?*

A key turning point

Having a trusted adult has been shown to be the main factor in helping children recover from traumatic events.

The availability of one key adult has been shown to be the turning point in many looked after young people's lives. (Gilligan, 2009)

- Most children and young people wrote that they had a trusted adult in their lives:
  - 100% of children (8-11yrs); and
  - 88.5% of young people (11-18yrs).
- Three young people had no such adult in their lives. Seven of the 33 young people chose not to reply to this question.

Being trusted and helping out

Children (8-11yrs) were asked if they *got the chance to help the teacher*.

Focus group feedback
Children had said in the focus groups that they were never trusted to show visitors around school or deliver a message because they were looked after.

- 35% of children (8-11yrs) responded that 'all or most of the time' they were asked to help and 53% answered 'sometimes'.
- Two children wrote 'hardly ever'.

We asked young people, *how often do you get the chance to show you can be trusted?*

Focus group feedback
Having trusting relationships and being trusted were key issues raised by the children in the focus groups that underpinned the development of this survey.

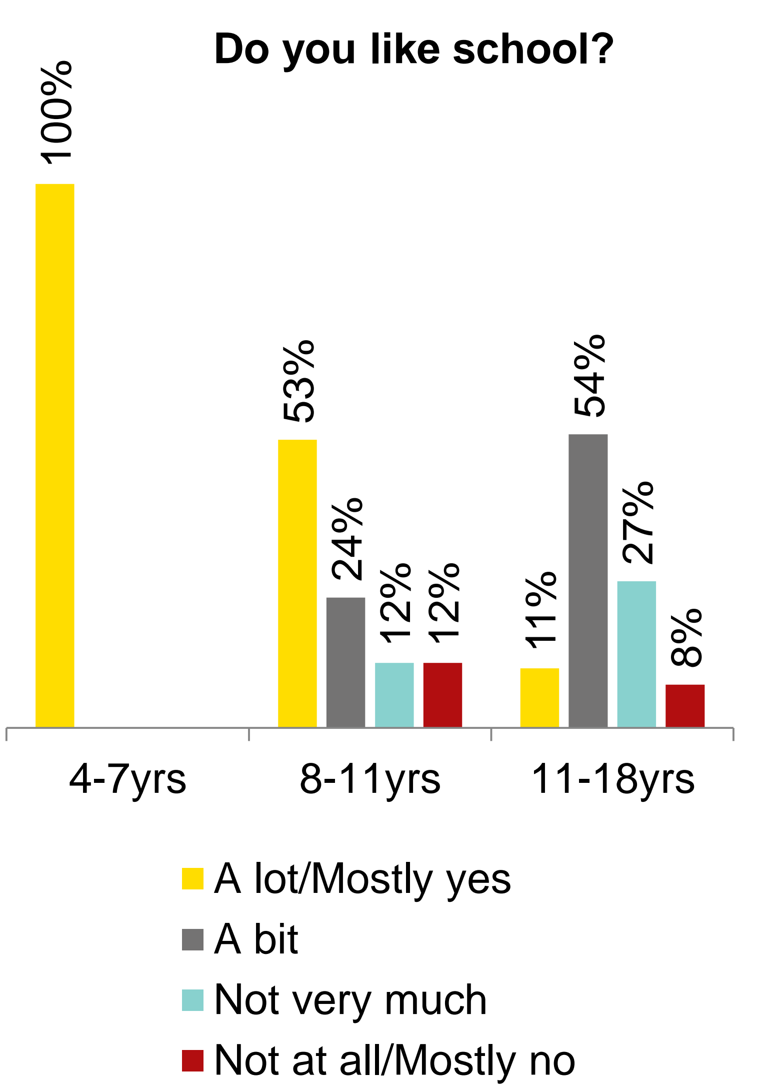
- 41% of young people (11-18yrs) thought they were given opportunities 'all or most of the time' to show they could be trusted and 45% given them 'sometimes'.
- Two young people responded 'hardly ever' and one felt they were 'never' trusted.

Liking school

All the children and young people were asked how much they *liked school or college.*

General population: Liking school
The *Health Behaviour in School-Aged Children Survey* (Wales, 2015) of 5,335 young people (11-16yrs) reported that 73% liked school 'a lot' or 'a bit' and 27% 'not very much' or 'not at all'. Liking school decreased with the child's age and girls were more likely to say they enjoyed school 'a lot' in comparison with boys.

- 65% of the 11-18yrs group liked school or college 'a lot' or 'a bit', which is a smaller proportion than reported by young people (73%) living in Wales and looked after young people (71%) in other Welsh local authorities.



Adults you live with: Support for learning

R E S I L I E N C E

Children in the 8-11yrs and 11-18yrs surveys were asked whether the adults they lived with (e.g. carers, parents) *showed an interest in what they were doing in school or college.*

General population: Support with learning

In comparison, the *Health Behaviour in School-Aged Children survey* (11-15yrs) reported that 90% of children in England felt that their parents were interested in what happened at school.

- 15 of the 17 children (8-11yrs) and all but one young person (11-18yrs) recorded that the adults they lived with showed an interest in their education ‘all or most of the time’ or ‘sometimes’.

- More (97%) looked after young people in Flintshire felt their carers showed an interest in their education than children (90%) in the general population and other looked after children (93%) reporting carer interest. This is a Bright Spot of practice.

RESILIENCE

Having fun & hobbies

Children aged 4-7yrs and 8-11yrs were asked if they had *fun at the weekend*.

The 11-18yrs survey asked young people if they were able to *spend time on their own hobbies or activities outside of school.*

- The majority of children and young people (94%) did have fun and took part in activities outside of school.

I would like to go split dancing.
4-7yrs

Age group	Yes, I have fun/take part in activities *n* (%)	Sometimes I have fun/ take part in activities *n* (%)	No, I don't have fun or take part in activities *n* (%)
4-7yrs	10 (100%)		
8-11yrs	9 (53%)	7 (41%)	1 (6%)
11-18yrs	15 (60%)	8 (32%)	2 (8%)
TOTAL	**34 (65%)**	**15 (29%)**	**3 (6%)**

Access to nature

Contact with nature can reduce stress and improve mental health. (Play England, 2012)

We asked whether children and young people had opportunities to *explore the outdoors,* such as visiting parks, beaches, and forests.

Focus group feedback
Some of the children in our focus groups said safeguarding fears limited their opportunities.

General population:
About 11% of children (6-15yrs) had not visited the natural environment in the last year. (National Survey for Wales – outdoor recreation, 2015)

- 76% of children (8-11yrs) and 100% of young people (11-18yrs) who answered felt that they got the opportunity to explore the outdoors 'all or most of the time' or 'sometimes'.
- The response from younger children in Flintshire was unexpected, as it is usually teenagers that report less access to nature and green spaces.

- In comparison with children (89%) in Wales overall, fewer looked after children (8-11yrs) in Flintshire felt they were given opportunities to enjoy the outdoors.

RESILIENCE

Second chances

Young people aged 11-18yrs were asked if they felt they *got second chances if they did something wrong.*

Focus group feedback

All children make mistakes and need a second or many more chances. It is part of learning and growing up.

Many children involved in the focus groups stated that looked after children were too readily refused a second chance.

- 58% responded 'all or most of the time';
- 33% answered 'sometimes'; and
- 8% thought they 'hardly ever' or 'never' got a second chance.

Some things that I did when I was younger and that … adults still talk about and they ask why I did it.
11-18yrs

Life skills

bright spots

We asked the young people in the 11-18yrs group, *how often do you get to practice life skills like cooking healthy food, washing clothes or going to the bank?*

Focus group feedback
This question was asked as many young people in the focus groups thought that they had been insufficiently prepared for independence.

- 96% of young people answered that they were taught independence skills 'all or most of the time' or 'sometimes' but 4% said this was 'hardly ever' or 'never' true.

- More young people felt they were being taught independence skills: 96% in Flintshire compared to 86% of looked after children in other Welsh LAs. This is a Bright Spot of practice.

R E S I L I E N C E

Access to Internet at home

Young people 11-18yrs were *asked if they could connect to the Internet from home.*

General population: Access to the Internet

- In Wales, 98% of households with children and two adults have an Internet connection. 90% of single parents have an Internet connection. (National Survey for Wales, 2017)
- The *Millennium Cohort Study* of children aged 11yrs old found that children who never used the Internet outside school had a high probability of low well-being. (The Children's Society Report, 2014)

- The majority (88%) of young people reported that they did have access to the Internet.
- Three young people were unable to connect to the Internet from their placement.

What would make care better?
Have Internet WiFi for my tablet/ device
11-18yrs

What would make care better?
Having the wifi code.
11-18yrs

4. Rights

- Included in decision making
- Stigma of being in care
- Feeling safe in placement
- Bullying
- Knowing and contact with social workers

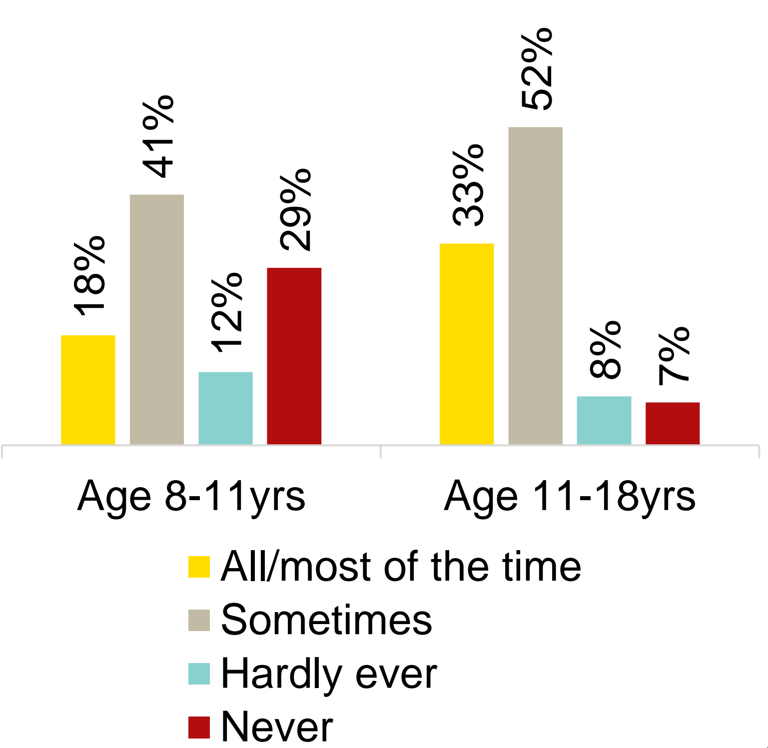
Included in decision-making

Children aged 8-18yrs were asked, *do you feel included in the decisions that social workers make about your life?*

- 59% of 8-11yrs felt included 'all or most of the time' or 'sometimes'.
- 85% of 11-18yrs 'all or most of the time' or 'sometimes' felt included.

They don't include the fact that I would like someone to be there as well.
11-18yrs

Do you feel included in the decisions that social workers make about your life?



RIGHTS

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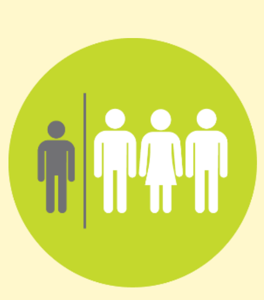
Stigma of being in care



The 11-18yrs age group were asked a question in the survey about feeling different, *do adults do things that make you feel embarrassed about being in care?*

Younger children were not asked these questions, as the focus groups suggested that being made to feel different was of much greater concern in adolescence.

- 19% of young people in Flintshire recorded that adults did things that made them feel embarrassed about being in care. This is a larger proportion than other looked after young people in Wales, where 14% said they felt embarrassed by adults.

They talk about it in front of other people who give me weird looks. 11-18yrs

Label us as looked after children. 11-18yrs

Not let us open a bank account. 11-18yrs

Not let me be in photos. 11-18yrs

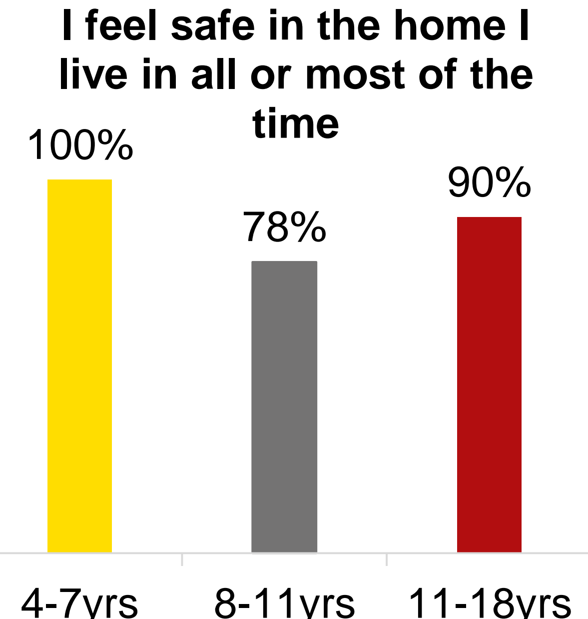
When I am at youth club I have staff with me. 11-18yrs

RIGHTS

Feeling safe in placement

All children (4-18yrs) were asked whether they *felt safe* in the home they lived in. It is difficult to know what children were thinking about when answering, but feeling secure is about how the world *feels,* not necessarily how it is.

- Overall, the majority of children and young people reported that they felt safe 'all or most of the time' in their placements.
- 4 (22%) children (8-11yrs) and 3 (10%) of the 11-18yrs group ticked the 'sometimes', 'hardly ever' or 'never' boxes.
- The proportion of children aged 8-11yrs not always feeling safe is concerning.



- A larger proportion of looked after young people felt safe in their homes compared to children in the general population. This is a Bright Spot of practice.

General population:
The Children's Worlds survey found that 75% of children (8-13yrs) in the general population felt 'Totally safe' at home (Rees *et al.*, 2014). Not feeling safe is associated with raised cortisol levels and difficulty in learning and concentration. (Harvard University, 2012)

R I G H T S

R I G H T S

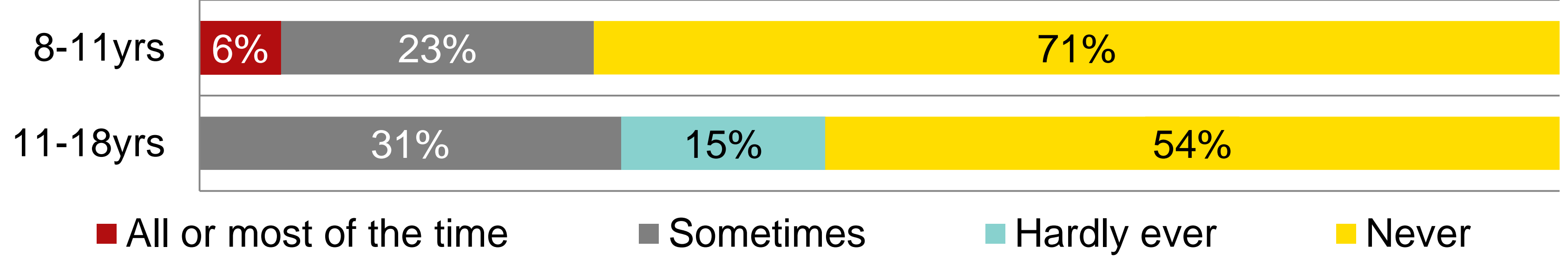
Bullying

Our question asked whether *children felt afraid of going to school because of bullying* and if they were bullied were they *getting support from an adult*.

General population: Bullying

- The analysis of the *Children's Worlds surveys* in 22 countries has shown that being free from bullying is one of the most important factors in children's well-being. (Rees *et al.*, 2010)
- About 10% of children in Wales say they are regularly bullied at school. (ONS, 2016b)

- One child (6%) aged 8-11yrs reported being afraid of bullying 'all or most of the time' and four children recorded 'sometimes'. All but one of these children felt they were getting support from an adult.
- Similarly few young people (11-18yrs) felt afraid to go to school because of bullying. Just 8 young people answered 'sometimes'. But two of the eight felt that they were not getting help or support from adults to stop the bullying.



Knowing identity of social workers

All the children and young people were asked if they *knew their current social worker.*

- Overall 19% of children and young people did not know who their social worker was.
- Half of the youngest children (4-7yrs) did not know their social worker.

Age group	**Know social worker** *n* **(%)**	**Don't know social worker** *n* **(%)**
4-7yrs	5 (50%)	5 (50%)
8-11yrs	14 (82%)	3 (18%)
11-18yrs	24 (92%)	2 (8%)
TOTAL	**43 (81%)**	**10 (19%)**

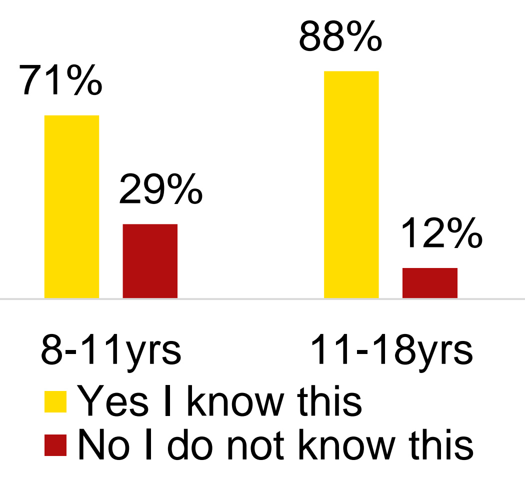
Contact with social workers

Children (8-11yrs) and young people aged 11-18yrs (*n*=38) who knew their social worker were asked how *easy it was to contact them.*

Children (8-11yrs) and young people (11-18yrs) were asked whether *they knew they could speak to their social worker on their own.*

A high proportion (87%) of young people (11-18yrs) reported that they could get easily get in touch with their social worker 'all or most of the time' or 'sometimes'. Just 3 young people (13%) could 'hardly ever' or 'never' get in touch with their worker.

- Fewer young people (11-18yrs) knew they could ask to speak to their social worker on their own compared to looked after young people in other Welsh local authorities: 88% in Flintshire compared to 98% elsewhere.



Try to call my social worker and she never answers. She doesn't tell me when she goes off.
11-18yrs

RIGHTS

5. Recovery

- Knowing reason for being in care
- Feeling settled in placement
- Liking bedrooms
- Adults you live with: Sensitive parenting
- Adults you live with: Sharing confidences
- Support with worries
- Parity with peers
- Happiness with appearance

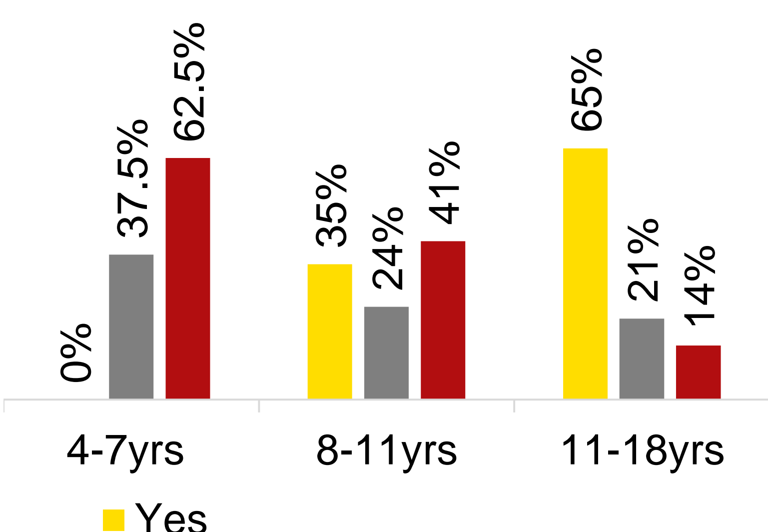
Knowing reason for being in care

All the children and young people were asked if *someone had explained why they were in care*.

Important for recovery

Having a coherent account of one's history and understanding the reasons that led to becoming looked after are important in the development of an integrated identity and in recovery from abuse and neglect. (Adshead, 2012; Adler, 2012)

- 62% of the youngest children (4-7yrs) felt that they did not understand why they were in care.
- Although understanding increased with age, more than a third (35%) of those aged 11-18yrs wanted to know and understand more about their history.



If I knew why I had a social worker I would understand more.
4-7yrs

RECOVERY

Feeling settled in placement

The surveys aimed to capture whether children felt a sense of belonging and felt at ease in their placements. Based on the advice from our focus groups, children and young people were asked,

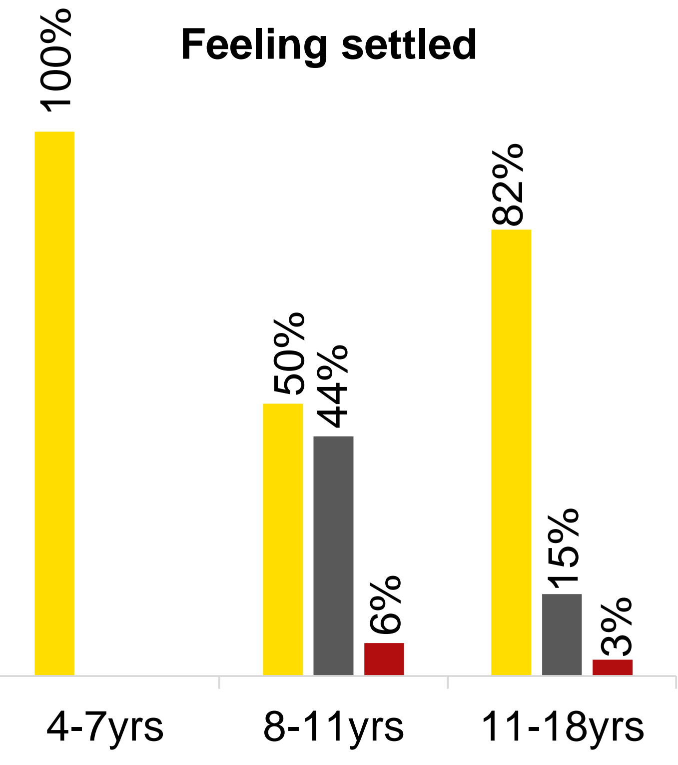
do you feel settled in the home you live in? (Do you feel comfortable, accepted and at ease?)

Answer options

Younger children (4-7yrs) could answer 'mostly yes' or 'mostly no'. Children (8-11yrs) and young people (11-18yrs) could answer: 'all or most of the time', 'sometimes', 'hardly ever', or 'never'.

- Most children and young people felt settled. The children aged 8-11yrs felt the least settled of all the age groups.

- More young people aged 11-18yrs (82%) in Flintshire felt settled than young people in other LAs where 73% 'always' felt settled. This is a Bright Spot of practice.

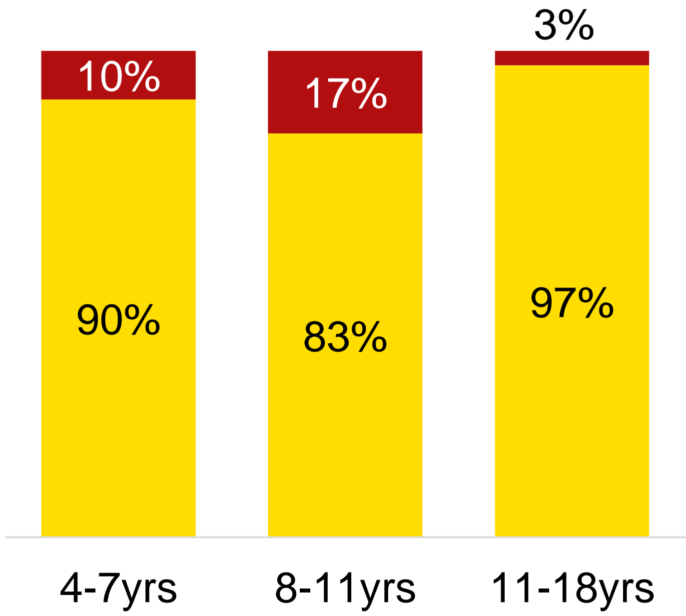


Liking bedrooms

Children and young people (4-18yrs) were asked *if they liked their bedroom*.

Focus group feedback
Liking your bedroom was an important feature for the focus groups we ran. Young people reflected that their bedrooms were a place for being on your own in busy homes.

It was linked to safety, a sense of identity and feeling a sense of belonging.



- 56 (92%) children and young people liked their bedrooms.

I want my own bedroom. But when we move I will have my own room.
4-7yrs

R E C O V E R Y

Adults you live with: Sensitive parenting

All children and young people (4-18yrs) were asked whether they felt the adults they lived with *noticed how they were feeling*.

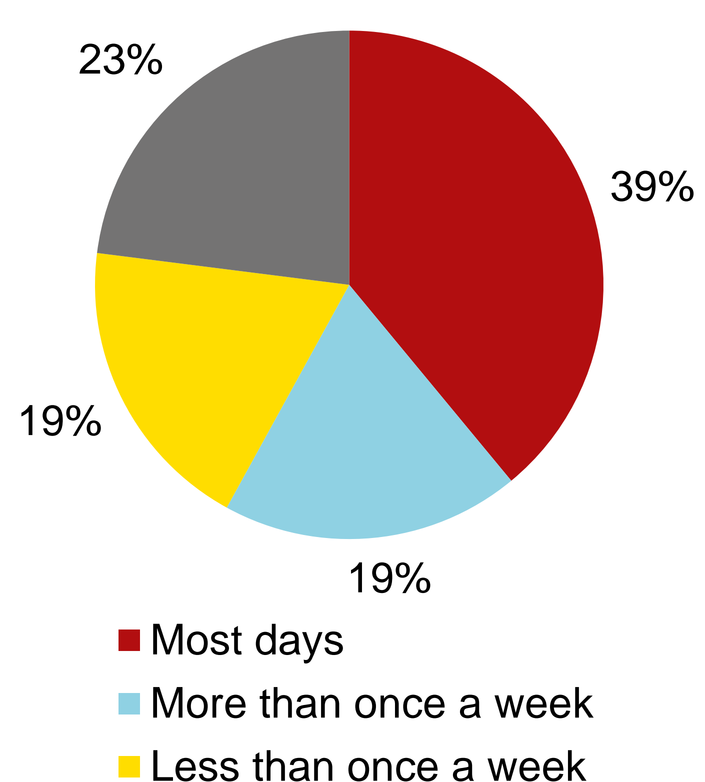
- 70% of younger children (4-7yrs), 77% of children (8-11yrs) and 92% of young people (11-18yrs) thought their carers noticed how they were feeling 'all or most of the time' or 'sometimes'.
- Young people (11-18yrs) in Flintshire were experiencing sensitive care. But the younger children (4-11yrs) did not respond as positively to this question, and fewer of them felt their carers noticed their feelings.

Adults you live with: Sharing confidences

Young people (11-18yrs) were asked how often they *talked to the adults that they lived with about the things that mattered to them.*

General population
The UK *Understanding Society* survey (2017) found that 65% of children (10-15yrs) talked regularly to a parent.

- 58% of looked after young people talked regularly with their carers about things that mattered to them.
- A smaller proportion confided in carers compared to peers in the general population where 65% talk regularly with a parent.



RECOVERY

Support with worries

Children and young people (8-11yrs and 11-18yrs) were asked if they *worried about their own feelings or behaviour* and, if they *did have concerns, were they receiving support.*

General population & other comparative data: Mental health

- Studies of looked after populations show that children's level of difficulties are much higher, ranging from about 45% of children in foster care to 75% of those in residential. (Ford *et al.*, 2007)
- In Wales about 17% of children have concerning SDQ scores that suggest they have a clinical level of mental health difficulties. (Statistical Bulletin 2017)

- One child (8-11yrs) worried 'all or most of the time' and six worried 'sometimes'. All thought they were getting help with their worries.
- 17% of young people (11-18yrs) worried 'all or most of the time' and 43% 'sometimes'.
- Three young people who reported worrying thought they were not getting support with their concerns.

I'd like to move further away so that if my dad gets out of prison he can't be near us. I don't want him to know where we live.
8-11yrs

Parity with peers

Young people (11-18yrs) were asked if they *got the chance to do similar things to their friends.*

- 88% of young people reported that 'all or most of the time' or 'sometimes' they did do similar things to their friends.
- Three (12%) young people reported that they could 'hardly ever' or 'never' do similar things to their friends.

It's difficult to tell your friends about your life.
11-18yrs

Happiness with appearance

Studies have shown that poor body image is associated with low self-esteem, depression and self-harm. (Cash and Smolek, 2011)

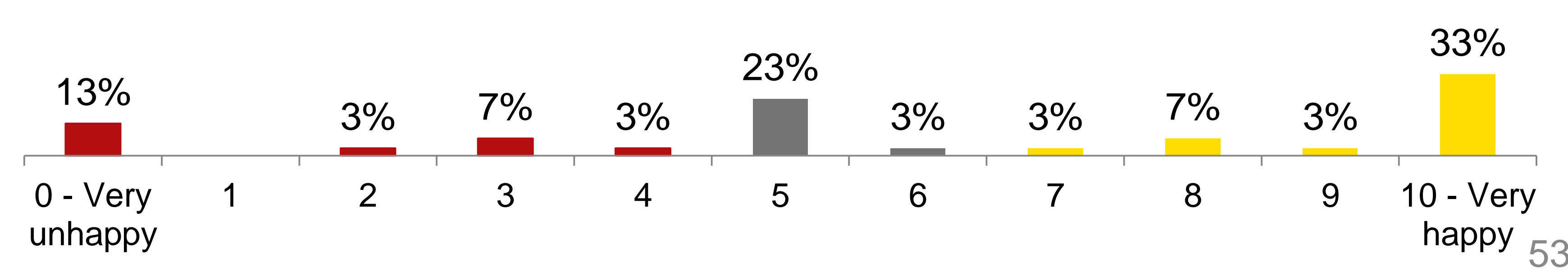
General population: Happiness with appearance

- 10% of 10-17 year olds in the general population are unhappy with their appearance. Girls are more likely to have a lower opinion of their appearance than boys. (The Children's Society, 2017)

- The majority of young people (11-18yrs) were happy with their appearance.

- 26% were unhappy with the way they looked: a larger proportion than the 10% of young people in the general population and the 19% of other looked after young people who dislike their appearance.

How happy are you with the way you look?



RECOVERY

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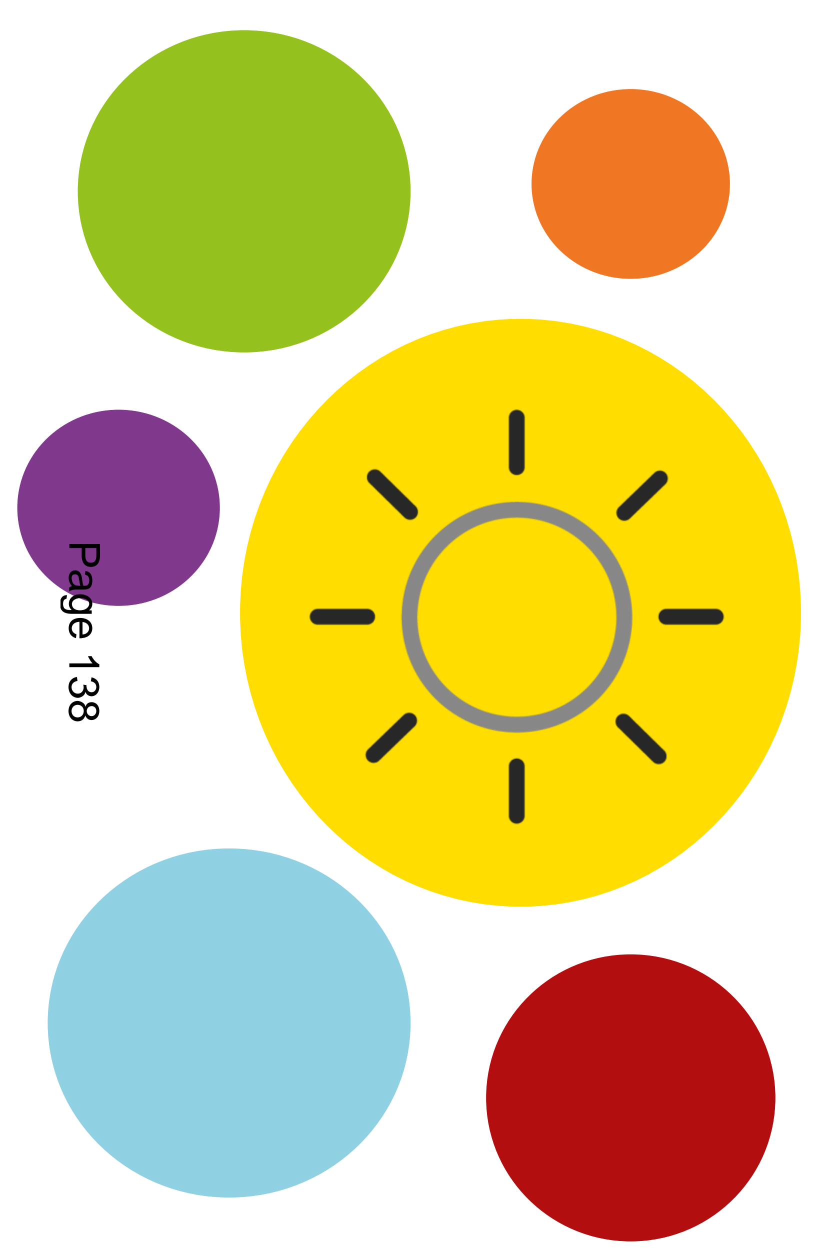

6. Well-being

- Happiness yesterday – affect
- Life satisfaction – overall evaluation
- Life is worthwhile – psychological/eudemonic well-being
- Life is improving
- Positivity about the future

Happiness

W E L L - B E I N G

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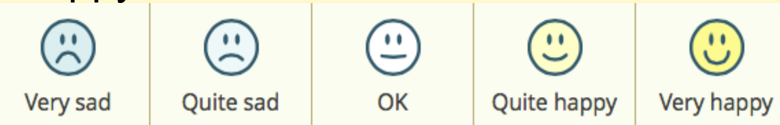
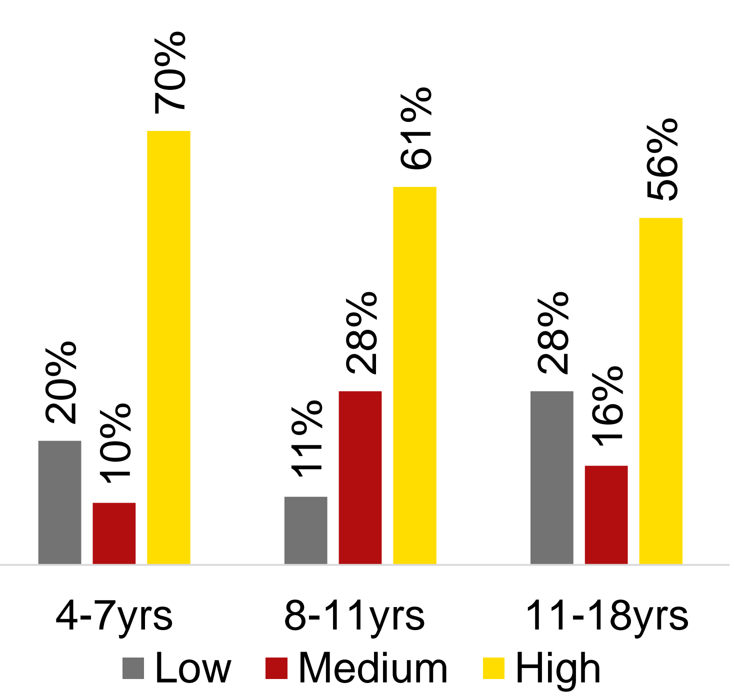
The decrease in happiness with age occurs in all surveys. Well-being decreases from school year 5 onwards with age 14-15yrs being the lowest point. It then starts to rise again. (Rees *et al.*, 2010)

- Children (4-7yrs & 8-11yrs) were asked to rate *how happy they were yesterday* on a five-point scale, from 'very sad' to 'very happy'.



- Young people (11-18yrs) selected a point on a 0-10 scale with 0 being 'very sad'.

- The majority of children and young people had been happy the previous day.
- 4 children (4-11yrs) and 7 young people reported that the previous day they had been 'quite sad' or 'very sad'.



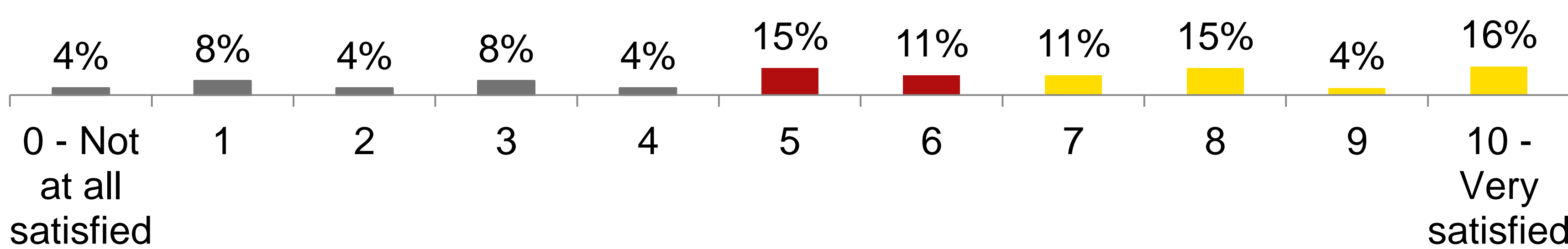
Life satisfaction

Young people (11-18yrs) were asked *how satisfied they were with their life* on a 0-10 scale.

This question exactly replicates The Children's Society survey question. A score of 7 or more is considered to be high life satisfaction. (The Cabinet Office, 2012)

- Unlike in the general child population there was no correlation between high life satisfaction scores and being happy at school.
- 73% of young people had moderate to high life satisfaction scores.

How satisfied are you with your life?



W E L L - B E I N G

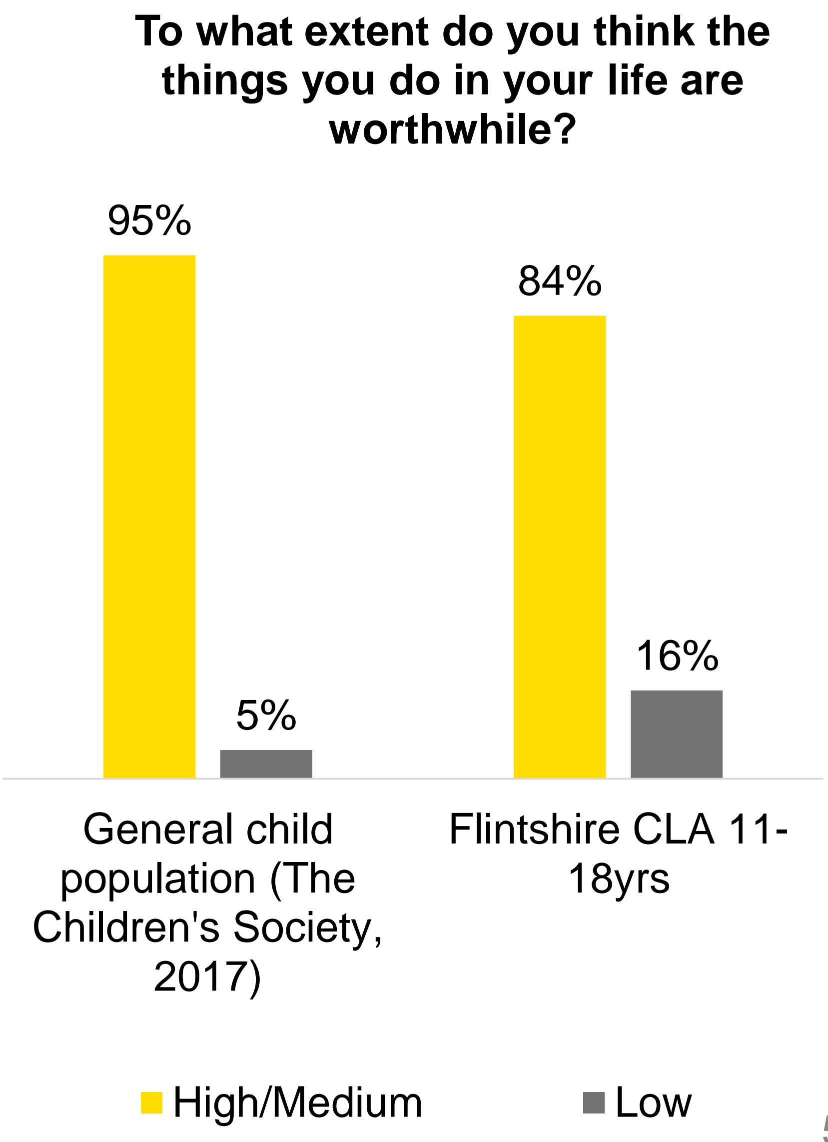
Are the things you do worthwhile?

Young people (11-18yrs) were asked *if the things they do in life are worthwhile*.

Importance of purpose
Having a meaning or a purpose to life is strongly associated with well-being. (ONS, 2014)

Young people (11-18yrs) completed the same 0-10 scale as used by The Children's Society (2017) in their household survey with 3,000 young people aged 10-17yrs.

- 56% of young people scored high or very high;
- 28% medium; and
- 16% low – feeling that the things they did were not worthwhile.



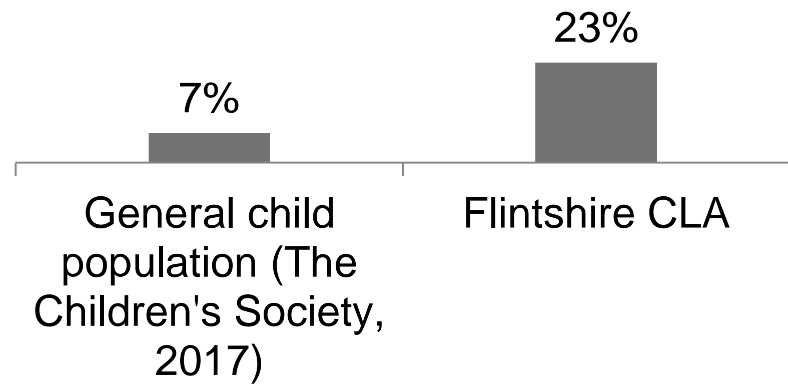
Positivity about the future

Young people (11-18yrs) were asked on a scale of 0-10 *how positive they were about the future.*

Links to happiness
Optimism about the future is linked with happiness and resilience. (Conversano et al., 2010)

- 16 (48%) were very positive about their future.
- Six (23%) young people had low scores and were pessimistic about their future.

Young people who were pessimistic about their future: comparison of Flintshire's 11-18yrs looked after young people with the general child population



W E L L - B E I N G

Comparisons

Levels of well-being – Flintshire's looked after young people (11-18yrs) compared to peers (10-17yrs) in the general population in Wales (ONS, 2016) and to the average scores of looked after young people in six Welsh LAs.

		Flintshire %	2018 average in 6 Welsh LAs %	Peers in general population (10-17yrs) %
Life satisfaction	High scores	46	55	80
	Low scores	28	17	8
Happiness yesterday	High scores	56	55	74
	Low scores	28	23	13
Things done are worthwhile	High scores	56	62	75
	Low scores	16	12	11
Positive about future	High scores	61.5	65	-
	Low scores	23	13	-

Life is improving

WELL-BEING

Children and young people aged 8-18yrs were asked whether they thought their *life was getting better,* and could choose from a five point scale ranging from 'a lot worse' to 'much better'.

- Half of the children (8-11yrs) and 79% young people (11-18yrs) felt that their lives were getting better.

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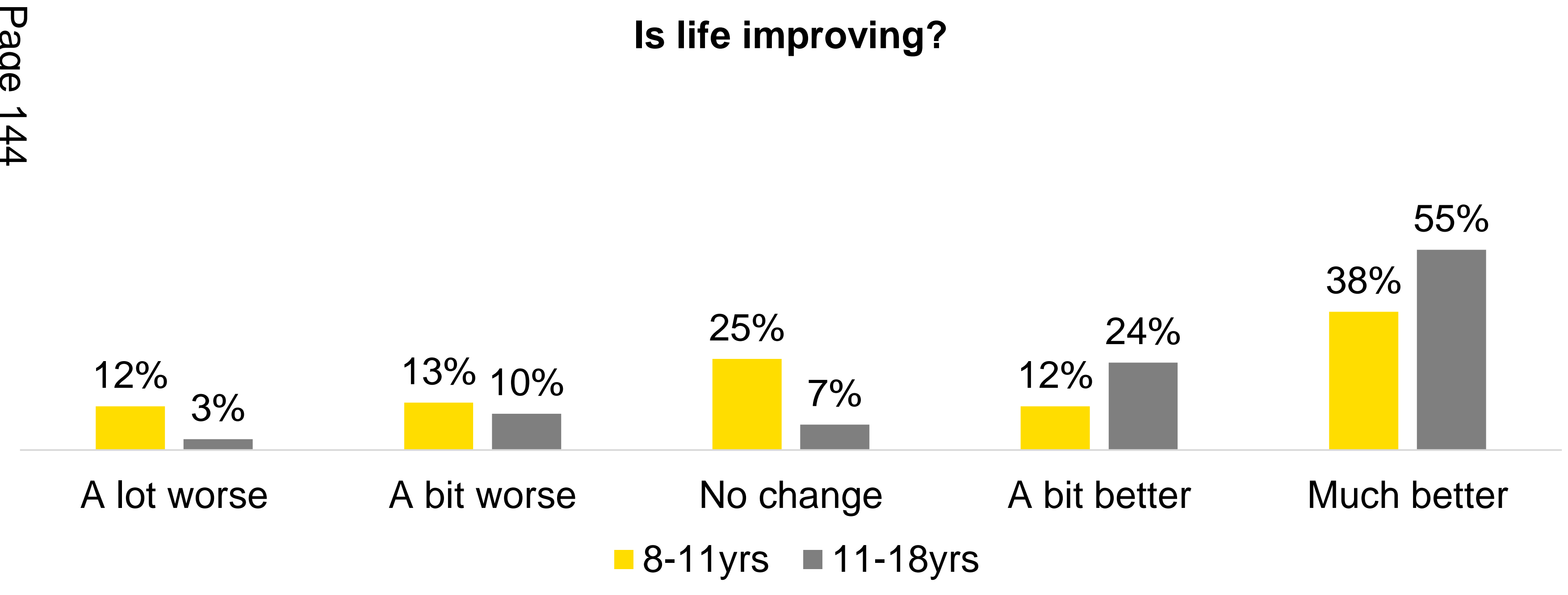

Well-being: 4-7yrs

Two of the 10 children in the 4-7yrs group described themselves as ‘very sad’.

- Both children were girls.
- Neither of them knew why they were in care.
- Both wanted more family contact.
- One child did not know who her social worker was and felt that her carers did not notice how she was feeling.
- The other child did not have a good friend and did not trust her social worker.

Well-being: 8-11yrs

Two of the 18 children in the 8-11yrs group described themselves as 'very sad'.

- Both children were girls.
- The children did not like school and were afraid to go to school because of bullying.
- The girls did not understand why they were in care.
- Neither of them knew that they could speak to their social worker in private and both recorded that they only trusted their social workers 'sometimes'.

Well-being:11-18yrs

Nine of the 33 young people had low well-being (i.e. scored 4 or less on two or more of the 0-10 well-being scales).

- Three of the young people were girls and six boys.
- The length of time in care and number of placements were not statistically associated with their low well-being.

Young people with low well-being were statistically more likely to:

- Not have a good friend;
- Not like their appearance;
- Not trust their social worker or feel they could easily get in touch with them;
- Not feel safe or settled in placements; and
- Have poorer relationships with their carers. None of the young people talked regularly with their carers about things that mattered.

Gender differences 11-18yrs

The Children's Society (2017) reported that in the general population one in seven (14%) girls (10-15yrs) were unhappy with their lives as a whole as were one in ten boys.

Examining gender differences in our surveys in 2017, we found no gender difference in the surveys for 4-7yrs and 8-10yrs but girls aged 11-18yrs were more likely to report low well-being. Girls were four times more likely to be unhappy with their appearance and this contributed to gender differences in well-being.

- More of the girls worried about their feelings or behaviours in comparison with boys.
- More girls than boys thought that their carers didn't notice how they were feeling.

- More boys than girls could not connect to the Internet from home.
- More boys than girls thought social workers were difficult to get in touch with.
- 33% of boys felt they were not included in decisions social workers made about their lives compared to none of the girls.

W E L L - B E I N G

Section 4: Children and young people's comments

Is there anything else you would like to tell us? What would make being in care better for you?

COMMENTS

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Comments: 4-7yrs

- Seven children gave text responses on: *What would make care better/ anything else you want to say?*
- Two children answered that there was nothing they wanted to change.
- Other children said:

To see my dad and grandad a bit more.

For my mummy to come to my house and have dinner with us. For my sisters and brothers to come and play with me.

What could make care better and other comments: 8-11yrs

- 8 children gave text responses on: *What would make care better/ anything else you want to say?*
- One child wrote that there was nothing they wanted to change.
- Other children wrote:

I would like an iPad and a cabin bed

Would like to have my phone with me more often.

I do not like being in care.

I want to know when I can back to live with my mum. I don't really know when this will be and nobody is telling me.

More regular contact with mum.

I want it to be more awesome.

COMMENTS

What could make care better and other comments: 11-18yrs

- 17 young people gave text responses on: *What would make care better/ anything else you want to say?*
- 7 young people recorded that there was nothing they wanted to change or that they were ok.
- Most young people wrote about wanting more family contact, writing for example:
  - *Move out of my care home and live with my family.*
  - *To be able to see my birth parents.*
- Other young people wrote:

Nothing as I'm happy with my life as it is.

New social worker if that can happen please.

If they didn't cut the funding for my clubs.

More fun things to do.

C O M M E N T S

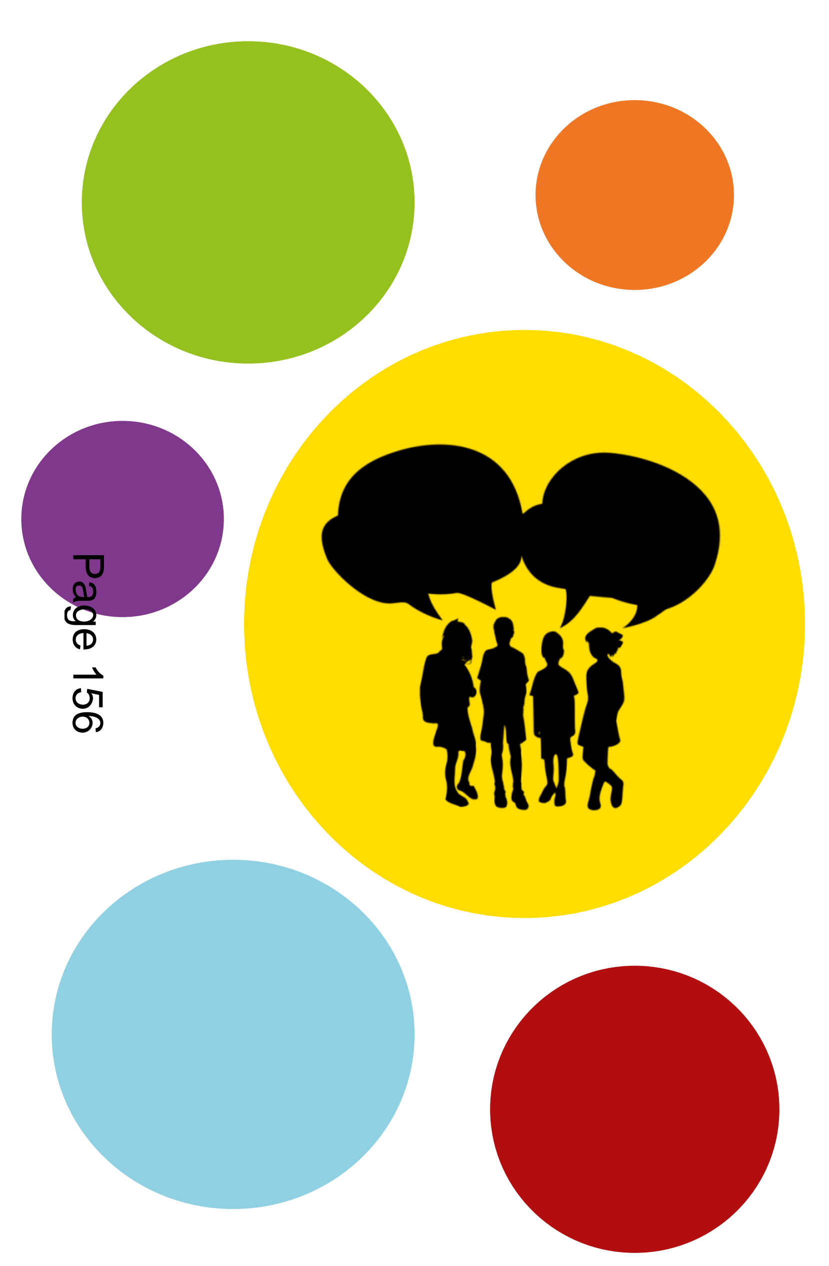
Section 5: Positive aspects of practice and areas for improvement

What’s working well

- The majority of the youngest children (4-7yrs) and young people (11-18yrs) in Flintshire felt safe and settled in their placements. All the youngest children (4-7yrs) and 90% of the young people (11-18yrs) reported feeling safe ‘all or most of the time’. Similarly, all the youngest children (4-7yrs) and 82% of the young people (11-18yrs) felt settled.
- Children and young people’s relationships with their carers were very good. The majority of children and young people (4-18yrs) trusted their carers and 97% thought that their carers were interested in their education. Carers in Flintshire are providing sensitive parenting to young people (11-18yrs). 92% of this age group felt their carers noticed how they were feeling. This is unusually high for this age group.
- More looked after children and young people were living in a household with a pet in comparison with children living in Wales and compared to other children in care.
- More young people (96%) in Flintshire felt they were being taught life skills compared to young people (86%) in other LAs.
- School is working well for the youngest children (4-7yrs) who are looked after in Flintshire. All of the youngest children (4-7yrs) reported enjoying school.

What could be improved

- **Explore why children aged 8-11yrs in Flintshire gave more negative responses** compared to the other age groups and similarly aged children in other local authorities**.**
- **Make sure that reviews of contact arrangements consider the views of all children.** It's important that the reasons for decisions are explained and that children are given the chance to ask questions about contact.
- **When making plans with children and young people, include unstructured opportunities to explore the outdoors** such as walking the dog or playing in a park as well as organised activities.
- **Ensure that all social workers introduce themselves to children and explain their roles in a child-friendly way.** Half of the youngest children (4-7yrs) did not know who their social worker was and some children and young people didn't know they could speak to their social worker in private.
- **Explain to children what has led to them coming into care and provide opportunities for them to ask questions.** Seven of the ten youngest children (4-7yrs) did not understand why they were in care and need help to understand what has happened and that they are not to blame.
- **Provide opportunities for young people (11-18yrs) to build self-esteem and positive self-image.** 26% of young people were unhappy with the way they looked which is a larger proportion than young people (10%) in the general population.
- **Consider how young people might be reassured about the support they can expect to receive in the future.**



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Understanding Society https://www.understandingsociety.ac.uk/

For enquiries about the Bright Spots project see:

http://www.coramvoice.org.uk/professional-zone/bright-spots

or contact:

brightspots@coramvoice.org.uk

Funded by the Hadley Trust

Your Life, Your Care: 4-7 year olds survey findings

We asked you some questions about what life is like for you. We asked lots of children in care the same questions. This is what you all told us and what we want to do.

YOU SAID

What was good?

- All of you liked school.
- All of you felt safe and settled where you live.
- All of you got the chance to have fun.
- Most of you wrote that you had a really good friend.
- Most of you said your carers noticed how you feel.

What was bad?

- Two of you said you felt ‘very sad’ the day before the survey.
- Only some of you knew why you were in care.
- Many of you did not know your social worker.
- Some of you said you would like to play outdoors more.

YOU SAID

If I knew why I had a social worker I would understand more.

I want my own bedroom. But when we move I will have my own room.

What would make care better?
For my mummy to come to my house and have dinner with us.

I would like to go Split dancing.

Space for local authority logo

Thank you to all of you who answered the questions. It really helped to read about how you feel. Because of what you told us Flintshire have decided to make some changes.

WE WILL

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bright spots

The survey was created together with children in care to ask about the things that were important to them. Coram Voice and University of Bristol have done the same survey in other local authorities and will bring together your responses to show what care is like for children across the country. If you want to find out more email: brightspots@coramvoice.org.uk

Your Life, Your Care: 8-11 year olds survey findings

We asked you some questions about what life is like for you. We asked lots of children in care the same questions. This is what you all told us and what we want to do.

YOU SAID

What was good?

- Almost all of you said you had a good friend.
- All of you said you had an adult who you can trust.
- Most of you said your carers were interested in what you did at school.
- Most of you had a pet where you live.

What was bad?

- Half of you did not feel your life was getting better.
- Some of you did not feel safe or settled where you live.
- Some of you did not feel included in decisions made about your life.
- Most of you didn't get the chance to help your teacher at school.

YOU SAID

I would like to see my mum more than once a month.

What would make care better?

No, nothing. I'm happy.

I would like to have contact in different places.

I would like it to be more awesome.

Space for local authority logo

Thank you to all of you who answered the questions. It really helped to read about how you feel. Because of what you told us Flintshire have decided to make some changes.

WE WILL

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bright spots

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Your Life, Your Care: 11-18 year olds survey findings

In February and March 2018, we asked you some questions about what life is like for you to understand how we can make it better. We asked lots of children in care the same questions. This is what you all told us and what we want to do because of what you said.

YOU SAID

What was good?

- Almost all of you felt safe where you live and said your carers noticed how you were feeling.
- Almost all of you thought your carers were interested in what you were doing at school or college.
- All of you who gave an answer trusted your carers.
- Most of you said you have a really good friend.
- Most of you, including all of the girls, felt included in the decisions made about your life.

What was bad?

- Several of you wanted more contact with your family, especially your mum, brothers and sisters.
- More than a third of you had had three or more social workers in the last 12 months..
- School could be better for lots of you.
- More than a third of you said no one had explained why you were in care or that you wanted to know more.
- Nearly a third of you felt unhappy and some of you worried about the future.
- A third of boys felt social workers made decisions without including them.

YOU SAID

They talk about it in front of other people who give me weird looks.

What would make care better?
Having the wifi code

What would make care better?
Nothing as I'm happy with my life as it is.

I would like to see my sisters more please.

Space for local authority logo

Thank you to all of you who answered the questions. It really helped to read about how you feel. Because of what you told us Flintshire have decided to make some changes.

WE WILL

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bright spots

The survey was created together with children in care to ask about the things that were important to them. Coram Voice and University of Bristol have done the same survey in other local authorities and will bring together your responses to show what care is like for children across the country. If you want to find out more email: brightspots@coramvoice.org.uk

Your Life, Your Care:

A survey of the views of looked after children and young people aged 4-18yrs in Flintshire

In Feb-Mar 2018 all children in care in Flintshire were asked to participate in an online survey. This is a summary of the findings.

61 children and young people responded the survey: a 36% response rate with boys under-represented.

KEY FINDINGS

What is working well?

The majority of the youngest children and young people felt safe and settled in their placements. All 4-7 year olds and 90% of 11-18 year olds reported feeling safe ‘all or most of the time’. Similarly, all the youngest children and 82% of the young people felt settled.

The majority of children and young people trusted their carers and 97% thought that their carers were interested in their education. Carers are providing sensitive parenting to young people (11-18yrs) – 92% felt their carers noticed how they were feeling, which is unusually high.

More looked after children and young people were living in a household with a pet in comparison with children living in Wales and compared to other children in care.

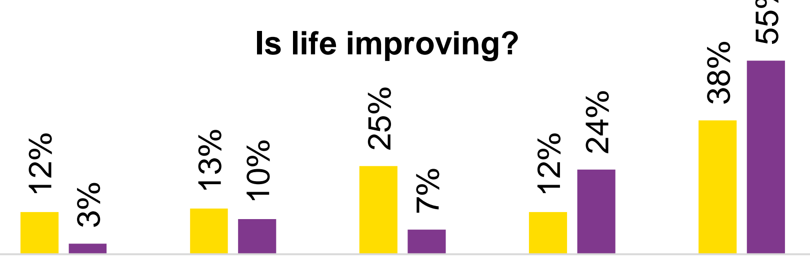
More young people (96%) in Flintshire felt they were being taught life skills compared to young people (86%) in other local authorities.

School is working well for the youngest children (4-7yrs) – all reported enjoying school.

What could make care better?
Nothing as I'm happy with my life as it is.
11-18yrs

I want it to be more awesome.
8-11yrs

I would like to go Split dancing.
4-7yrs



11-18yrs

KEY FINDINGS

What could be improved?

4-7 year olds

The majority (62%) of younger children (4-7yrs) did not understand why they were in care.

Half of this age group did not know who their social worker was

If I knew why I had a social worker I would understand more.
4-7yrs

8-11 year olds

There were only 18 responses from the 8-11yrs age group but they were the least settled in their placements.

- Only 50% thought their lives were improving
- Four (22%) felt they were unable to explore nature and the outdoors in comparison with 11% of Welsh children.

All the children (8-11yrs) and 73% of young people (11-18yrs) had contact with at least one parent. Most children and young people wanted longer and more frequent contact with relatives and more information about why contact decisions had been made.

I would like to see my sisters more please.
11-18yrs

I would like to have contact in different places.
8-11yrs

What would make care better?
For my mummy to come to my house and have dinner with us.
4-7yrs

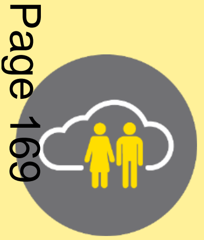
More than a third of 11-18yrs had had three or more social workers in the previous year.

KEY FINDINGS

Low well-being

Two of the ten children aged 4-7yrs gave responses that suggested they had low well-being. The children did not understand why they were in care, wanted more family contact, and had poorer relationships with adults and peers.

The two children in the 8-11yrs group with low well-being disliked school, were afraid of bullying and had poor relationships with their social workers.



Nine of the 33 young people (11-18yrs) had low well-being. These young people were more likely to not feel safe or settled in placements, not have a good friend, not like their appearance and lack trusting relationships with carers and social workers

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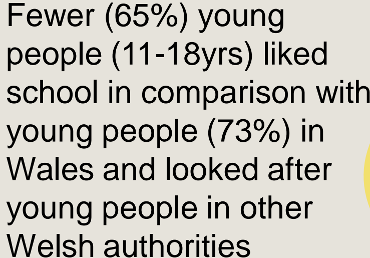
Comparison to other young people

Fewer (65%) young people (11-18yrs) liked school in comparison with young people (73%) in Wales and looked after young people in other Welsh authorities



Young people (19%) in Flintshire felt embarrassed by adults drawing attention to their care status more frequently than young people (14%) in other Welsh local authorities.

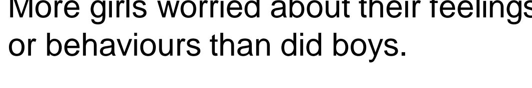
Although half of young people had high well-being in all areas, more looked after young people (11-18yrs) were dissatisfied with their lives and not as happy or optimistic about their futures as other young people living in Wales.

The survey results suggest about a quarter of the young people need to have targeted interventions that focus on improving relationships (e.g. with carers, social workers and friends).

Gender differences – 11-18 year olds

In comparison with girls, fewer boys reported being able to access the Internet outside school.

More boys found their social workers difficult to get hold of and felt excluded from social work decision-making.



More girls worried about their feelings or behaviours than did boys.

Girls felt their carers were less sensitive to their feelings.

KEY FINDINGS

Recommendations

- **Explore why children in Flintshire aged 8-11yrs gave more negative responses** compared to the other age groups and compared to similarly aged children in other local authorities.
- **Make sure that reviews of contact arrangements consider the views of all children.** It is important that reasons for decisions are explained and that children are given the chance to ask questions about contact.
- **When making plans with children and young people, include unstructured opportunities to explore the outdoors** such as walking the dog or playing in a park as well as organised activities.
- **Ensure that all social workers introduce themselves to children and explain their roles in a child-friendly way.** Half of the youngest children (4-7yrs) did not know who their social worker was and some children and young people didn't know they could speak to their social worker in private.
- **Explain to children what has led to them coming into care and provide opportunities for them to ask questions.** Seven of the ten youngest children (4-7yrs) did not understand why they were in care and need help in understanding what has happened and that they are not to blame.
- **Provide opportunities for young people (11-18yrs) to build self-esteem and positive self-image.** 26% of young people were unhappy with the way they looked which is a larger proportion than young people (10%) in the general population.
- **Consider how young people might be reassured about the support they can expect to receive in the future.**

This survey was developed by Coram Voice and University of Bristol together with 140 children and young people in and from care as part of the national **Bright Spots Programme.**

It asks children in care about their life, based on the things that are important to them.

To find out more go to: www.coramvoice.org.uk/brightspots

Or email brightspots@coramvoice.org.uk

SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE

Date of Meeting	Thursday, 15th November 2018
Report Subject	Forward Work Programme
Cabinet Member	Not applicable
Report Author	Social & Health Care Overview & Scrutiny Facilitator
Type of Report	Operational

EXECUTIVE SUMMARY

Overview & Scrutiny presents a unique opportunity for Members to determine the Forward Work programme of the Committee of which they are Members. By reviewing and prioritising the Forward Work Programme Members are able to ensure it is Member-led and includes the right issues. A copy of the Forward Work Programme is attached at Appendix 1 for Members' consideration which has been updated following the last meeting.

The Committee is asked to consider, and amend where necessary, the Forward Work Programme for the Social & Health Care Overview & Scrutiny Committee.

RECOMMENDATION	
1	That the Committee considers the draft Forward Work Programme and approve/amend as necessary.
2	That the Facilitator, in consultation with the Chair of the Committee be authorised to vary the Forward Work Programme between meetings, as the need arises.

REPORT DETAILS

1.00	**EXPLAINING THE FORWARD WORK PROGRAMME**
1.01	Items feed into a Committee's Forward Work Programme from a number of sources. Members can suggest topics for review by Overview & Scrutiny Committees, members of the public can suggest topics, items can be referred by the Cabinet for consultation purposes, or by County Council or Chief Officers. Other possible items are identified from the Cabinet Work Programme and the Improvement Plan.
1.02	In identifying topics for future consideration, it is useful for a 'test of significance' to be applied. This can be achieved by asking a range of questions as follows: 1. Will the review contribute to the Council's priorities and/or objectives? 2. Is it an area of major change or risk? 3. Are there issues of concern in performance? 4. Is there new Government guidance of legislation? 5. Is it prompted by the work carried out by Regulators/Internal Audit?

2.00	**RESOURCE IMPLICATIONS**
2.01	None as a result of this report.

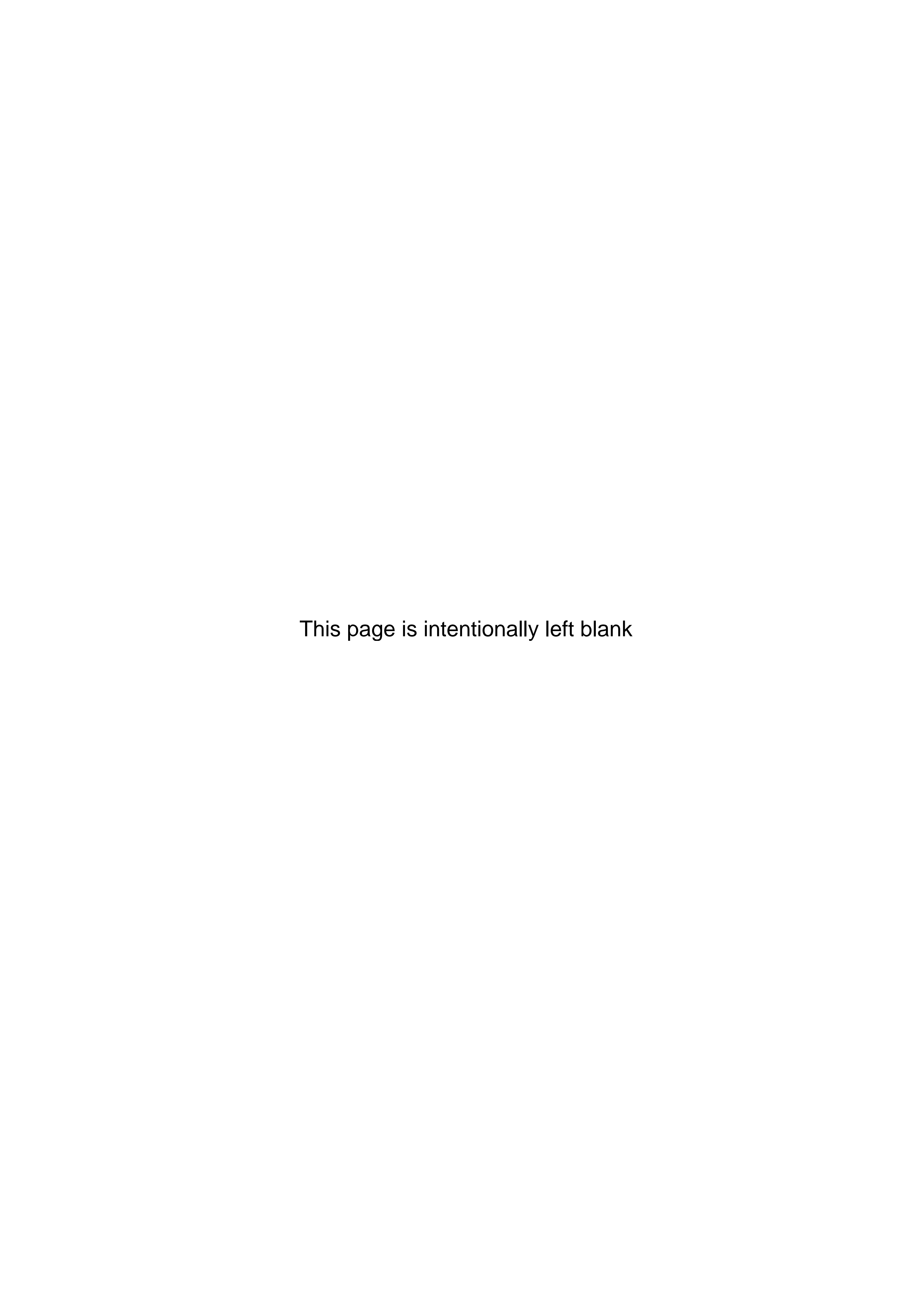
3.00	**CONSULTATIONS REQUIRED / CARRIED OUT**
3.01	Publication of this report constitutes consultation.

4.00	**RISK MANAGEMENT**
4.01	None as a result of this report.

5.00	**APPENDICES**
5.01	Appendix 1 – Draft Forward Work Programme

6.00	**LIST OF ACCESSIBLE BACKGROUND DOCUMENTS**
6.01	None. **Contact Officer:** Margaret Parry-Jones Overview & Scrutiny Facilitator **Telephone:** 01352 702427 **E-mail:** margaret.parry-jones@flintshire.gov.uk

7.00	**GLOSSARY OF TERMS**
7.01	**Improvement Plan:** the document which sets out the annual priorities of the Council. It is a requirement of the Local Government (Wales) Measure 2009 to set Improvement Objectives and publish an Improvement Plan.



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CURRENT FWP

Date of meeting	Subject	Purpose of Report	Scrutiny Focus	Responsible / Contact Officer	Submission Deadline
13th December 2pm	**Council Plan 2018/19 Mid-Year Monitoring** **Update on Flint and Holywell Extra Care facilities**	To enable members to fulfil their scrutiny role in relation to performance monitoring To receive a progress report.	Performance monitoring/assurance Assurance	Facilitator Chief Officer Social Services	
31st January 10.00 am 2019	**Community Health Council** (to be confirmed) **Parenting Programme**			Facilitator Chief Officer Social Services	
28th March 2pm 2019	**Learning Disability Day Care and Work Opportunities Alternative Delivery Model** **Q3 Council Plan monitoring**	To receive a progress report on the first year of operation as an alternative delivery model. To enable members to fulfil their scrutiny role in relation to performance monitoring	Assurance Performance monitoring/assurance	Chief Officer Social Services Facilitator	
23 May 2019 10.00 am	**Third Sector update**	Annual review of the social care activities undertaken by the third sector in Flintshire		Chief Officer Social Services	

	Comments, Compliments and Complaints **Annual Directors Report**	To consider the Annual Report To consider the draft report.		Chief Officer Social Services Chief Officer Social Services	
18 July 2019	**2018/19 Year End Reporting Council Plan Monitoring** **BCUHB & Welsh Ambulance Services NHS (Trust to be confirmed)**	To enable members to fulfil their scrutiny role in relation to performance monitoring To maintain regular meetings and promote partnership working.	Performance monitoring/assurance Partnership working	Facilitator Facilitator	

Regular Items

Month	Item	Purpose of Report	Responsible/Contact Officer
Nov/Dec	**Safeguarding**	To provide Members with statistical information in relation to Safeguarding - & Adults & Children	Chief Officer (Social Services)
May	**Educational Attainment of Looked After Children**	Education officers offered to share the annual educational attainment report with goes to Education & Youth OSC with this Committee.	Chief Officer (Social Services)
May	**Corporate Parenting**	Report to Social & Health Care and Education & Youth Overview & Scrutiny.	Chief Officer (Social Services)
May	**Comments, Compliments and Complaints**	To consider the Annual Report	Chief Officer (Social Services)
June	**Betsi Cadwaladr University Health Board Update**	BCUHB are invited to attend on an annual basis – partnership working.	Facilitator