SOCIAL SERVICES AND HEALTH CARE OVERVIEW SCRUITNY COMMITTEE

Date of Meeting	Thursday 12th December 2019
Report Subject	Safeguarding Adults and Children
Cabinet Member	Cabinet Member for Social Services
Report Author	Chief Officer Social Services
Type of Report	Operational

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 and corporate 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.

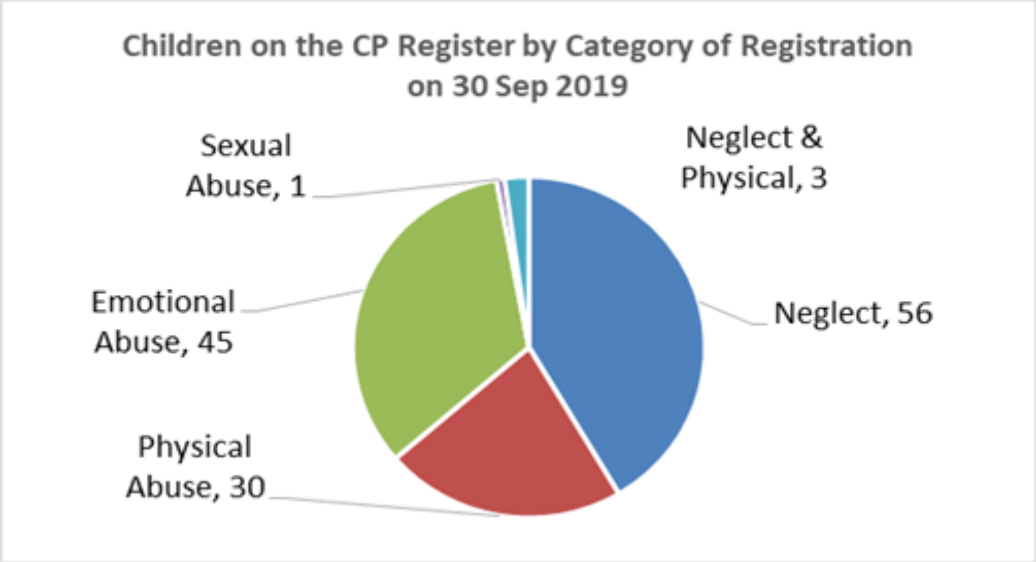
RECOMMENDATIONS	
1	That members accept this report as relevant information in relation to Flintshire Safeguarding for the period 1st April 2018 to 31st March 2019 and additional information provided.
2	That members take due regard to the variety of activity across the Safeguarding Unit and the continuing development and improvement in service provision.

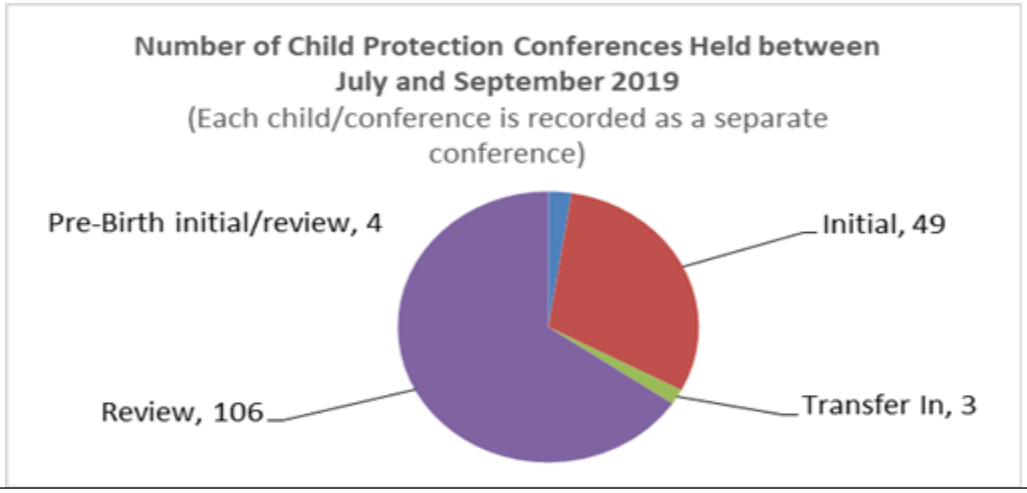
REPORT DETAILS

1.00	EXPLAINING THE ACTIVITY OF THE SAFEGUARDING UNIT
1.01	The Flintshire Safeguarding Unit has been a single unified team since early 2016. The Safeguarding Unit Service Manager reports directly to the Senior Manager for Safeguarding and Commissioning. The team currently comprises 22 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) The Safeguarding Unit team are also involved in regional groups; delivery groups, policy and procedures, performance and quality audit groups, delivery of training for both adults and children, child practice review and adult practice reviews when required and investigations. Key messages from the last quarter Regional Board meetings are available in the appendices. Since September 2018, in addition to our own internal case file audits, partnership audits for children have been completed on Repeat registrations, the quality of our support to children and young people at risk from domestic abuse, outcomes for children who are deregistered, and quality of pre-birth assessments. Partnership audits for adults have been completed on quality of the multi-agency safeguarding reports, the effectiveness of the our response up to the end of the Enquiry stage, the effectiveness of our response from Strategy Discussion to Case Conference, how well we engage with individuals during the Safeguarding process, and the effectiveness of joint working with individuals who self-neglect. The Safeguarding Unit has also had two successful CIW thematic inspections this year in February and October. The Adult and Children's Safeguarding Service was inspected in February and the Looked After Service in October along with other areas of Children's Services.
1.03	**New National Safeguarding Procedures** Wales has become the first part of the UK to introduce a single set of safeguarding guidelines to help protect children and adults at risk with the launch of the new Wales Safeguarding Procedures mobile app. Launched at the start of National Safeguarding Week, November 11th – 15th 2019, the Wales Safeguarding Procedures will standardise safeguarding practice across Wales and between agencies and sectors. The procedures will set out what to do if anyone working with children or

	adults suspect an individual is experiencing, or at risk of, abuse, neglect or other kinds of harm. Uniquely there will be no printed copies of the procedures. Instead they will be available to everyone online, either via the dedicated Wales Safeguarding Procedures website or a mobile app. This means that there will always be a single up-to-date version available to all practitioners. It will also make finding information quick and easy. 'Pointers for practice' are featured throughout both the web and app versions of the procedures and provide simple 'how to' guidance for practitioners. These draw on the latest research and practice developments. Both platforms will also feature a searchable glossary. This will make it easier for people to work in partnership by ensuring that every practitioner is using the same terminology in the same way, irrespective of their sector or professional discipline. Training on the key changes in the procedures is commencing in the New Year across Wales with regional and local implementation expected from 1st April 2020.
1.04	**Deprivation of Liberty Safeguards (DOLS)** The Safeguarding Unit has two full-time Best Interest Assessors (BIAs) and a part time BIA who between them are responsible for undertaking Best Interest Assessments for individuals who meet criteria in accordance with the Mental Capacity Act Deprivation of Liberty Safeguards. The Safeguards apply to people in care homes and hospitals, and the local authority is responsible for assessing Flintshire residents in care homes. A person is 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 and by a specialist doctor. Numbers of applications have increased year on year from thirteen applications in 2013-2014 (before a significant new judgement, known as Cheshire West, widened the scope of DoLS) to a total of 447 new applications being received between April 1st 2018 and March 31st 2019. 183 applications have been made for the six months between 1st April, 2019 and 30th September, 2019. The number of referrals received means that careful prioritisation is need to ensure that those most in need receive assessments.
1.05	**New Liberty Protection Safeguards (LPS)** It has been recognised nationally that DoLS is "not fit for purpose", as the numbers of people deprived of their liberty exceed the resources available to manage the assessments required. In 2018 the UK Government published a Mental Capacity (Amendment) Bill which became law in April 2019 and will be implemented in October 2020. The Bill set out a new model, the Liberty Protection Safeguards, which will replace DoLS in England and Wales.
1.06	The Liberty Protection Safeguards will: • Cover people of sixteen years and over (DoLS applied to people of eighteen and over)

	• Apply to people living in the community as well as to people in care homes and hospitals • Put more responsibility on the providers and commissioners of care to gather together the assessments required and to send them into the responsible body. • Expect the responsible body (which will in many cases be the local authority) either to authorise the deprivation of liberty or, if the person being assessed appears to be objecting to the placement, to arrange for a more in-depth assessment from an Approved Mental Capacity Professional. • Give people the right to appeal to the Court of Protection if they wish to appeal against the deprivation of their liberty. A Code of Practice is being prepared and the Welsh Government are considering any funding implications for introducing the new scheme. A full programme of training and implementation will be rolled out by Social Services over the coming year. Initial training has already taken place with senior managers and relevant providers and an internal project manager has been appointed to drive the implementation.
1.07	**Adult Safeguarding and Adults at Risk** The Social Services and Wellbeing (Wales) Act 2014 (SSWBA) expects the Local Authority to undertake relevant enquiries and decide on next steps within 7 working days of receipt of an adult safeguarding report. Between 1st April 2018 and 31st March 2019, 679 adult safeguarding referrals were received at the Single Point of Access (SPOA), with 97% of enquiries being completed within seven days. This reflected an increase from 528 referrals the previous year, when 94% of enquiries were completed within seven days. Over the six months from April 1st, 2019, 416 reports have been received, suggesting that we are likely to see a significant annual increase in referrals by the end of March, 2020. Referrals are becoming more complex and financial abuse is an increasing trend within Adult Safeguarding.
1.08	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.
1.09	**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.

1.10	**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 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. At the end of March 2019 there were **131 children** on the register, **111** of them Flintshire children. As of 14th November there were **161** children on the register, comprising **149** Flintshire children, 12 temporary registrations.
1.11	**Categories of Risk** For the past two years the highest category has been emotional abuse as a single category with the next highest being Physical and Emotional abuse. This year the highest category currently is Neglect closely followed by Emotional Abuse. Emotional Abuse unfortunately continues to be linked with high levels of reported Domestic Abuse, usually linked to alcohol and/or drug misuse. 
1.12	**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 30 September 2019, 3 young people from 3 families had been on the CPR for more than 12 months, the longest being 25 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. All cases of re-registration within 12 months of de-registration are audited on behalf of the Safeguarding Board each year. During the period 01/04/2018 to 31/03/2019, there were 5 children from 3 families registered to the Child Protection Register within 12 months of their previous registration. All cases involved domestic violence, parental alcohol abuse and the inability of parents to engage consistently with services.
1.13	**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 above. From April 2018 to March 2019, 89% of initial child protection conference and 99% of review conferences were carried out within statutory timescales. From 1st April 2019 to 30th September 2019, 89% of initials and 99% of reviews were held in timescales. The last quarter returned 100% compliance for both initial and review case conferences. 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. 76 family Child Protection Conferences were held in Quarter 2, for 162 children. 

1.14	**Looked After Children** The number of Looked After Children has previously remained relatively steady but has been increasing both locally, regionally and nationally. At the end of October 2018 there were 239 children being looked after by the Local Authority. Between 1st April 2018 and 31st March 2019, 78 children started to be looked after. Between 1st April and 30th September 2019, 31 children started to be looked after, 18 have left care and there have been 52 placement moves. Flintshire are currently looking after 261 children. 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. This has an evident impact on available resources.
1.15	Another role of the Safeguarding Unit is to ensure partner agencies and social work colleagues are fully aware of safeguarding processes so that they can fulfil their duties under the Social Services and Well-Being Act. 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 and Children's Safeguarding is delivered effectively and consistently. A further piece of work raising awareness of safeguarding issues and the duty to report concerns regarding Child Sexual Exploitation, Missing Children, Modern Slavery and Trafficking has been commenced by the Licensing Team in conjunction with Safeguarding colleagues. It is now a mandatory requirement for private hire and hackney carriage drivers to undertake safeguarding training. During October 412 drivers, operators and desk operators attended safeguarding training. It was arranged by the Licensing Team and delivered by the NSPCC. Six different 2 hour slots were offered. A further free session will be arranged in January 2020 to capture any drivers who were unable to attend the October dates, or those who have recently obtained their licence.
1.16	**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.
1.17	**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, one CPR report was published earlier this year and one APR report was finalised recently. The action plan is already being reviewed within partner agencies and Social Services. There is work on a second APR in progress and a second CPR. There is also a DHR in progress. The CPR is about the Flintshire mother who was convicted of the manslaughter, by drowning, of her baby daughter in July 2015. She was just over 1 year old and was a twin. A CPR was commenced initially,

	however, was put on hold until the criminal proceedings were complete. A learning event has been booked in March 2020 and the panel are currently collating timelines from all agencies. The APR is about an adult without capacity who was resident in a local care home. Some of the issues were linked to professionals having problems dealing with his challenging behaviour, questions about whether he was in the correct support placement and subsequent questions about care received when transferred to hospital following a fall. Following the death of woman in Flintshire in October 2018 a DHR was commissioned by the Flintshire Community Safety Partnership. The review is still on-going, and FCC are fully committed to supporting the requirements of the DHR, and provide information as and when required. Partner agencies are in the process of completing Individual Management Referrals, which in turn will assist the Author to draft their report. The DHR Panel have been meeting on a regular basis. This was the case of Theresa Garner, killed in a Domestic Homicide (October 2018) by her husband John Garner. He was later convicted in May 2019 of her murder. 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, however, the Board has addressed this issue through recent training.
1.18	**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 • Specific recommendations from other Local Authority CPRs/APRs can come from other agencies for action within Social Services. 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.
1.19	**Domestic Homicide Review** The purpose of a DHR is to examine the circumstances that led to a reported death and review the contact that organisations had with the victim and offender also identifying lessons to be learnt.

	The last Flintshire Domestic Homicide Review was published on the Flintshire County Council website in July 2018 however, another DHR is currently in progress as detailed above.
1.20	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 resource 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**
	None

6.00	**LIST OF ACCESSIBLE BACKGROUND DOCUMENTS**
6.01	**Wales National Safeguarding Procedures** http://www.safeguarding.wales/ http://www.diogelu.cymru/ **Wales National Safeguarding Procedures Frequently Asked Questions** Safeguarding Procedures Frequently Asked Questions **Links to Regional Safeguarding Board 7 minute briefings** https://www.northwalessafeguardingboard.wales/resources/7-minute-briefings/ **Key messages from Regional Safeguarding Board September 2019** Key Messages NWSB

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7.00	**GLOSSARY OF TERMS**
7.01	(1) **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. (2) **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. (3) **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.' (4) **Liberty Protection Safeguards:** The Liberty Protection Safeguards will replace DoLS and is due to be implemented in October 2020. LPS will: • Cover people of sixteen years and over (DoLS applied to people of eighteen and over) • Apply to people living in the community as well as to people in care homes and hospitals • Put more responsibility on the providers and commissioners of care to gather together the assessments required and to send them into the responsible body. • Expect the responsible body (which will in many cases be the local authority) either to authorise the deprivation of liberty or, if the person being assessed appears to be objecting to the placement, to arrange for a more in-depth assessment from an Approved Mental Capacity Professional. • Give people the right to appeal to the Court of Protection if they wish to appeal against the deprivation of their liberty.