

#### SOCIAL AND HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE

Date of Meeting	Thursday 3 <sup>rd</sup> December 2020
Report Subject	Safeguarding Adults and Children's Annual Report to include the "New Safeguarding Procedures"
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, including the response to the COVID 19 pandemic.

The report will also update members with brief details about the new Wales Safeguarding procedures.

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

RECO	DMMENDATIONS
1	That members accept this report as relevant information in relation to Flintshire Safeguarding for the period 1 <sup>st</sup> April 2019 to 31 <sup>st</sup> March 2020 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 23 people and is based in County Offices Flint. They have close working relationships with Children and Adult Social Care and key partner agencies both locally and regionally.
1.02	The Safeguarding Unit oversees all aspects of work related to their core responsibilities which are:
	The Safeguarding Unit team are also involved in Regional Safeguarding Board sub-groups including 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.
	In addition to our own internal case file audits, the team have completed audits to support practice and development of internal teams within Children's Services and Adult Services.
1.03	Impact of COVID 19 and response of the Safeguarding Unit
	Whilst this report focuses on the data analysis and narrative of the period April 2019 – March 2020, the period since late March 2020 to date has brought many challenges to the Unit as processes have adapted to working under local and National restrictions linked to the pandemic.
	The Safeguarding Unit in its entirety moved to a 'working from home' model which is still in place at the current time. Processes were swiftly adapted to ensure business as usual was maintained and statutory responsibilities were met. The team were fortunate to be able to continue their work remotely and have adapted to the use of dial in facilities or video conferencing facilities for all aspects of their work. High standards have been maintained, timescales have been adhered to and professional partnerships and business relationships have continued.
	Flintshire were one of the first areas in North Wales to move their entire child protection case conferencing and Children Looked After Reviews to a remote platform within the first week of lockdown restrictions. Adult Safeguarding Strategy meetings have continued using dial in or Webex facilities and our Best Interest Assessors have maintained a presence, within government guidelines, in the Care Homes in order to fulfil their duties under DOLs. Social workers within the Adult Safeguarding and Adult at Risk teams have followed local and government guidelines and

supported people in the community, safeguarded individuals and continued their community work where needed.

## 1.04 Adult Safeguarding under COVID 19

In the early part of April and May 2020, the adult safeguarding team experienced a sharp reduction in the amount of referrals from care homes and the general public. This was reflected across the region. There was however an increase in requests for assistance and advice directly linked to COVID anxiety and concern, including referrals from carers under increasing amounts of stress due to respite services in lockdown.

S126 enquiries under Adult Safeguarding processes continued however, enquiries, particularly where health were involved, were more time consuming. Strategy meetings convened using virtual facilities were well attended and it was noted that participation improved.

Although Welsh Government have paused performance reporting for the recent period, the Safeguarding Unit have continued to meet all relevant targets and monitor their performance. Between 1<sup>st</sup> April and 30<sup>th</sup> September 2020, of the 291 referrals received since the pandemic commenced 282 have had their enquiries completed within 7 working days (97%)

In mid-Summer it was noted that referrals were back on a par with those from last year and this pattern has continued.

## 1.05 Child Protection and Children Looked After Under COVID 19

For child protection and Children Looked After, COVID did not substantially reduce the work coming through the front door. Numbers on the register were already high at the start of lockdown and continued to rise as referrals for those needing the highest protection continued to be sent into the Local Authority. The Safeguarding Unit quickly adapted their processes to meet statutory responsibilities whilst always being mindful to ensure children and families could engage with virtual processes safely. Independent Reviewing Officers were innovative in their communication with children and young people using virtual means to ensure their voice was heard.

#### 1.06 **Positive learning from COVID 19**

Whilst nobody would choose to work under such challenging circumstances as has been experienced over the past few months, the Safeguarding Unit never lost focus on protecting children, young people and adults at risk and ensuring our processes adapted and evolved in the continually changing work environment of the pandemic.

The Safeguarding Unit have learned they are able to work in a dynamic way using technology to ensure statutory responsibilities are fulfilled. It is anticipated that the team will continue to work remotely for the immediate future however, it is hoped that at some point the team will be able to combine a more physical presence with a remote platform.

Maintaining good performance under such unprecedented circumstances is a testament to the Safeguarding Unit's priority of ensuring the most vulnerable adults, children and families are safeguarded.

## 1.07 | New National Safeguarding Procedures

In November 2019, Wales 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 11<sup>th</sup> – 15<sup>th</sup> 2019, the Wales Safeguarding Procedures hoped to standardise safeguarding practice across Wales and between agencies and sectors. The procedures 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 are no printed copies of the procedures. Instead they are 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 feature a searchable glossary which makes 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 commenced in January across Wales with regional and local implementation expected from 1<sup>st</sup> April 2020. However, due to the pandemic, National implementation of the procedures was delayed until 1<sup>st</sup> September 2020. Flintshire fully adopted the procedures from this date.

Many of the changes within the children's procedures are about practice. The procedures place an emphasis on aspects such as co- production, person centered approaches, advocacy, use of reflective practice and practitioner judgement. Importantly, there is a strong focus on the 'daily lived experience of the child and their carer' which forms an integral part of information gathering, assessments and recording. The procedures refer to the Social Worker "seeing the child", not just setting eyes on them. Safeguarding processes remain largely consistent to the previous All Wales Procedures with some key changes. The Regional Safeguarding Board has produced a 'quick guide' to the key changes for both adults and children and these can be found in the appendix. Flintshire produced a Practice Directive to ensure changes were understood locally.

## 1.08 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 13 applications in 2013-2014 (before a significant new judgement, known as Cheshire West, widened the scope of DoLS) to the number of applications received in 2019/20 being 383. This includes only a week of the first lockdown in Wales. The number of referrals received means that careful prioritisation is need to ensure that those most in need receive assessments.

The impact of the lockdown was felt in the subsequent months when access to people residing in care homes was restricted or in many cases, not allowed at all. All of the applications received in the period came from Care Homes. The majority of people were located in Flintshire homes, however a substantial amount of people were in placements outside the reporting authority, which made assessments more difficult to obtain after March 2020. Whilst travel was legitimate, access to people in Care Homes was limited.

The data available shows that 30% of those applications received are in progress with 35% having been approved. Over 33% were withdrawn either due to people moving or sadly dying before the applications could be processed. The majority of Relevant Person's Representatives are paid representatives, with the other 45% being a family member, friend or carer.

Throughout the period of Covid-19 restrictions, assessors have been working imaginatively to gather the best information they can about the person they are assessing. This has included, where appropriate, video calls, meeting people outside, telephone calls and even interviewing people through windows. In each case the assessors have based their approach on an individual assessment of the communication skills of the person, and on the safety requirements of the home. Keeping the person at the centre of the assessment has been a priority and the supervisory body gratefully acknowledges the support of the care homes and our assessors in making sure we have been able to continue to provide this person-centred response.

## 1.09 | 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 was due to be implemented in October 2020. The Bill set out a new model, the Liberty Protection Safeguards, which will replace DoLS in

England and Wales. The new implementation timescales will now take place in April 2022, with an implementation period of 6 months to follow.

## 1.10 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.

The LPS scheme applies to community settings, as well as to care homes and hospitals. It also applies to anyone from 16 years old and above, rather than 18 as is the case with DoLS.

LPS will introduce a two-tier system of protection. This means that in most cases the 'responsible body' (the Local Authority for social care cases and the NHS for hospitals) would rely on a number of assessments to establish whether the planned care arrangements are 'necessary and proportionate' to meet the individual's needs. In most cases the responsible body will scrutinise the assessments and, if appropriate, authorise the deprivation of liberty. In complex cases an Approved Mental Capacity Practitioner will be appointed to carry out a more detailed assessment, which will include an interview with the person in question.

The Safeguarding Unit continue to work to current DoLS guidance while preparing for the implementation of LPS.

## 1.11 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 1<sup>st</sup> April 2019 and 31<sup>st</sup> March 2020, 602 adult safeguarding reports that met the threshold for enquiries under Section 126 were completed, with 95% of enquiries being completed within seven days. This reflected an increase in demand from 551 reports the previous year, when 95% of enquiries were completed within seven days. Over the six months from April 1<sup>st</sup> 2020 to 30<sup>th</sup> September 2020, 288 reports have been received at the Single Point of Access (SPOA), reflecting a reduction in reports during the early pandemic period. However, the referral rate has now recovered to near normal.

Referrals are becoming more complex and financial abuse is an increasing trend within Adult Safeguarding. The number of Adult Safeguarding reports have continued to increase putting pressure on the

team to screen initial referrals and undertake our duty to enquire. Year on year the number of safeguarding referrals has increased from 440 in 2016/17, 526 in 2017/18, 679 in 2018/19 and 736 2019/20.

1.12 The Adult Safeguarding Team have convened 201 strategy meetings between 1st April 2019 and 31st March 2020.

The Adult Safeguarding Team undertake internal audits on a regular basis to identify areas for development and ensure consistency of approach. Flintshire employs an Adult Safeguarding Social Worker whose role is to enquire and investigate referrals as required and to work closely with families and individuals to keep them informed of the process, the actions being undertaken and the outcomes. As a result of this work we have noticed that very few individual or families ask to be involved with Case Conferences as they have already been a part of the process and fully engaged. The increase in staff for the Adult Safeguarding Unit will also allow us to ensure that all families and adults at risk are informed at each stage of the process. Our numbers for adult safeguarding conferences remain low.

The team are continuing to promoting the use of advocates to allow those with no voice to be engaged in the process. The role of advocates is integral to a number of areas of work within safeguarding. Advocacy Services are used as Relevant Person's Representatives (RPRs) when undertaking DOLS assessments. When Adult Safeguarding reports are received, consideration is always given to the subject of the referral and whether they require independent advocacy services to ensure their needs are met and their voice is heard.

## 1.13 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 same categories are reflected in the new Wales Safeguarding Procedures. 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 Wales Safeguarding Procedures .

## 1.14 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 2019 there were **131 children** on the register, **111** of them Flintshire children.

At the end of March 2020 there were 201 **children** on the register. By the end of September 2020 there were **209 Flintshire children** on the register, with 33 temporary registrations totalling 242 children.

As of 23<sup>rd</sup> November there were **197** children on the register, comprising **176** Flintshire children, 21 temporary registrations.

It should be noted that other areas in North Wales have experienced similar high levels of registered children. An internal audit was undertaken earlier in the year to determine whether there were any trends or reasons for the high numbers. Over the past 12 months we have had large number of multiple sibling families which has increased the overall total. The audit did not identify any concerns in practice. The numbers now are starting to decrease as children who have been registered for a period of time are supported in non-statutory ways.

## 1.15 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. Emotional Abuse unfortunately continues to be linked with high levels of reported Domestic Abuse, usually linked to alcohol and/or drug misuse.

## 1.16 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 3<sup>rd</sup> 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 2020 14 young people from 9 families had been on the CPR for more than 12 months, the longest being 56 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 01/04/2020 to 30/09/2020, there was one child registered to the Child Protection Register within 12 months of their previous.

#### 1.17 Number of Child Protection Case Conferences held

The breakdown for the number of case conferences held is given below. Up to 8 conferences 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 2019 to March 2020, 93.5% of initial child protection conferences and 99.3% of review conferences were carried out within statutory timescales. From 1<sup>st</sup> April 2020 to 30<sup>th</sup> September 2020 during the pandemic, 94.5% of initials and 99% of reviews were held in timescales, all using remote virtual facilities.

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.

700 Child Protection Conferences were held between 1st April 2019 and 31 March 2020.

## 1.18 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 September 2020 there were 285 children being looked after by the Local Authority, 81 with Flintshire Foster Carers and 120 living with their parents or with relatives under connected person arrangements. Three Special Guardianship Orders have been made so far this year.

Between 1st April 2019 and 31st March 2020, 42 children started to be looked after.

Between 1<sup>st</sup> April 2020 and 30th September 2020, 32 children started to be looked after, 23 have left care and there have been 39 placement moves.

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. During the pandemic, travel has been restricted and the IROs have not been ravelling to placements addresses unless absolutely necessary. Contact with children, families and foster carers has been maintained using virtual platforms.

## 1.19 Links to the Regional Safeguarding Board

The Strategic shared priorities of the Board are:

(1) Exploitation (2) Domestic Abuse and (3) Improving Awareness and Compliance around the Adults at risk process in North Wales

#### **Exploitation**

ICF Funding was secured for a social worker and two support workers to expand the Adults at Risk team. The new posts are supporting Flintshire's Single Point of Access to identify appropriate support for adults at risk of abuse, including victims of exploitation and domestic abuse. Flintshire Safeguarding Unit have a regular presence at monthly VARM (Vulnerable and Risk Management) meetings to ensure individuals who may require support outside normal criteria are picked up. Flintshire also attend the relatively new Modern Slavery and Human Trafficking MARAC meeting. This is a police led regional meeting supported by various agencies and has links to the NRM unit. The forum seeks to ensure the right support is in place for those individuals at risk of exploitation in any form.

#### **Domestic Abuse**

There has been a steady increase in the numbers of adults at risk linked to incidences of Domestic Abuse over the last year. This was particularly noticeable following local restrictions put in place following the outbreak of the Covid pandemic. Flintshire Safeguarding Unit have a regular presence at the monthly MARAC meeting and have robust processes in place to ensure all referrals linked to any form of Domestic Abuse are actioned appropriately. The new support staff within the Unit will develop links to DASU and work with victims to access support through Women's Aid, Housing, benefits and other services where required.

#### **Awareness**

There are three levels of awareness raising training in Flintshire. A Corporate Safeguarding e-learning module was launched in September 2019 providing employees with basic awareness of safeguarding, and 179 staff from all departments of the Council participated and were asked to share their awareness with colleagues. There is also a day's general training in adult and children's safeguarding available for staff working in the care sector, and a half day advanced day in using the procedures provided by the adult safeguarding manager

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 with training moving to a virtual platform due to the pandemic.

# 1.20 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 multiagency 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. 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.

## 1.21 Flintshire APRs, CPRs and DHRs

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 work on a CPR ongoing which is due for publication soon. The process has been delayed by the pandemic. There is a report due for an APR and also there is 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. The report is due for ratification by the Regional Board hopefully this year.

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. The investigation has been completed and the report is due ratification by the Regional Board this year.

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. The review is in its final stages. 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.

## 1.22 | 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.

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 implication arising from this report.

3.00	CONSULTATIONS REQUIRED/CARRIED OUT
3.01	N/A

5.00	APPENDICES
5.01	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 FAQs
	https://www.northwalessafeguardingboard.wales/wp-
	content/uploads/2019/11/Wales-Safeguarding-Procedures-Frequently-
	Asked-Questions.pdf
	https://www.bwrdddiogelugogleddcymru.cymru/wp-
	content/uploads/2019/11/Cwestiynau-Cyffredin-am-Weithdrefnau-
	<u>Diogelu-Cymru.pdf</u>
	Wales National Safeguarding Procedures What has changed Adults
	https://www.northwalessafeguardingboard.wales/wp-
	content/uploads/2020/06/Whats-Changed-Adults-Eng.pdf
	https://www.bwrdddiogelugogleddcymru.cymru/wp-
	content/uploads/2020/06/Beth-syn-Wahanol-Diogelu-Oedolion.pdf
	Wales National Safeguarding Procedures What has changed Adults
	https://www.northwalessafeguardingboard.wales/wp-
	content/uploads/2020/06/Whats-Changed-Children-Eng.pdf
	https://www.bwrdddiogelugogleddcymru.cymru/wp-
	content/uploads/2020/06/Beth-syn-Wahanol-Diogelu-Plant.pdf

7.00	CONTACT OFFICER DETAILS
7.01	Contact Officer: Jayne Belton, Safeguarding Unit Service Manager Telephone: 01352 702600 E-mail: Jayne.Belton@flintshire.gov.uk

## 8.00 **GLOSSARY OF TERMS** (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.