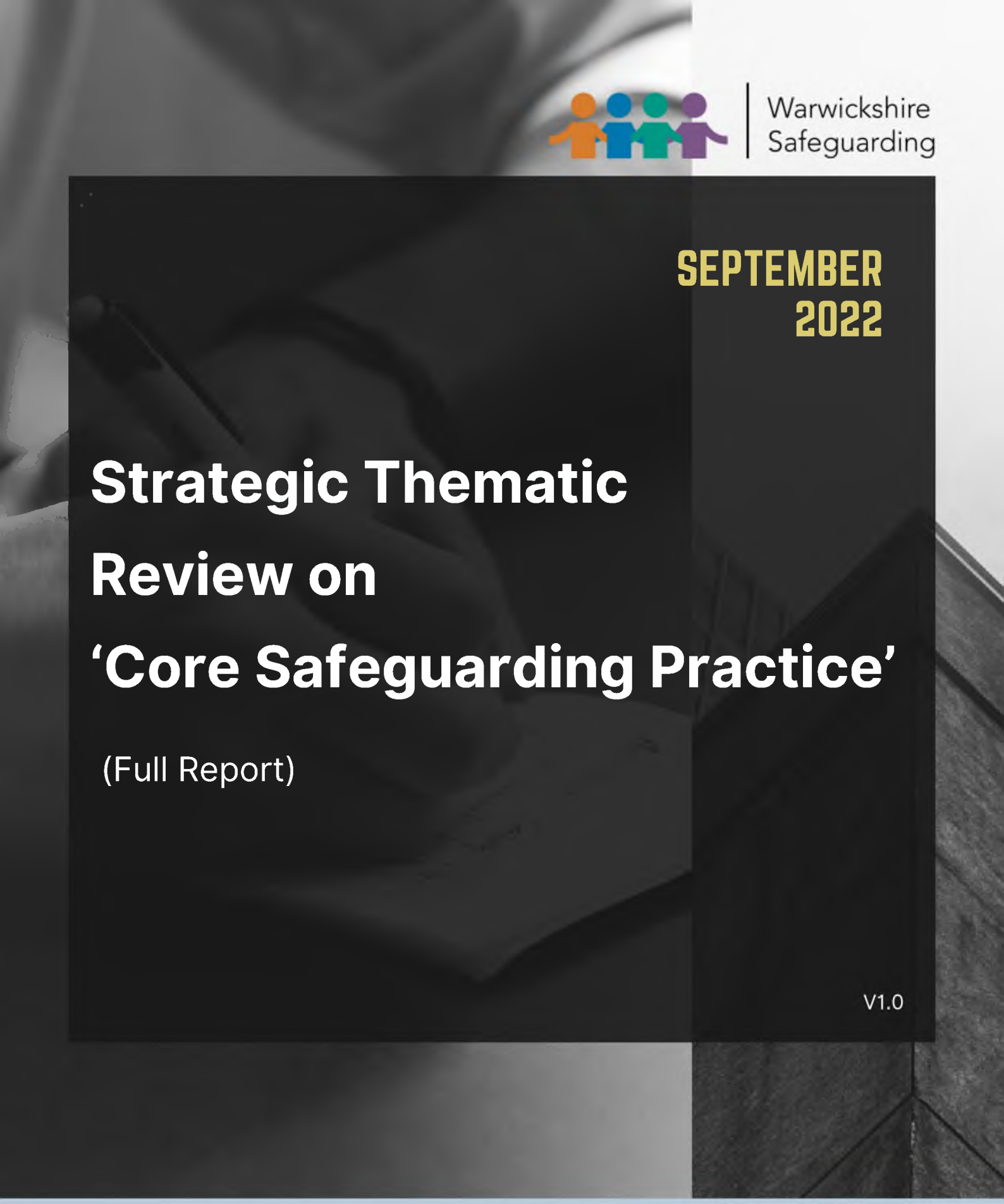


Warwickshire Safeguarding

SEPTEMBER 2022

Strategic Thematic Review on 'Core Safeguarding Practice'

(Full Report)

V1.0

Produced by Warwickshire Safeguarding

Approved by WSEB: 22.09.2022

CONTENTS

3 Background, Methodology & Purpose
4 Self-Evaluations
5 Case File Audits and Lessons from Published Safeguarding Reviews
6 Feedback from Professionals, Service Users and their Families
8 Key Findings: Leadership and Accountability
14 Key Findings: Policies, Procedures and Protocols
23 Key Findings: Recruitment and Selection
26 Key Findings: Staff Training and Development
33 Key Findings: Complaints, Allegations and Whistleblowing
36 Key Findings: Information Sharing, Communication & Confidentiality
47 Key Findings: The Voice of the Child, Young People & Adults
52 The Journey of the Child / Adult
56 Voices from Child Safeguarding Practice Reviews and Safeguarding Adults Reviews
59 Conclusion and Message from Independent Chair & Scrutineer
60 Appendix.1 – Summary overview of key strengths and areas for improvement

BACKGROUND

Warwickshire Safeguarding's new partnership arrangements published in June 2019 set out proposals for the scrutiny and assurance of safeguarding practice throughout Warwickshire. These arrangements consider successes and challenges, identify learning, make suggestions and recommendations for improvement and monitor the progress of these improvements to ensure they are embedded into future practice across partner agencies. Warwickshire Safeguarding Executive Board (WSEB) determined that the focus of the second thematic review would be 'Core Safeguarding Practice' (children & adults) and, as such, the thematic review has been completed, with the report below detailing the findings. An 'Executive Summary' will also be made available.

METHODOLOGY AND PURPOSE

The review process followed a triangulation approach, which is used to prepare and gather evidence during quality assurance processes *(Figure 1)*. It helps ensure that we can be confident that we have investigated any areas of interest from multiple angles and any decisions we take about areas for development are robust and evidence based.

Figure 1: Scrutiny and Assurance Framework

SELF-EVALUATIONS

The purpose of the self-evaluation is to provide an overview of the core safeguarding arrangements that are in place within partner agencies across the county; with agencies being asked to reflect upon their current position and score themselves as to how well they are meeting the required standards. At the end of the self-evaluation there is provision for agencies to consider where improvements can be made and to identify how they will achieve this.

Self-evaluations were completed by 25 agencies ranging from statutory providers, voluntary agencies and service providers *(Figure 2)*; in addition, the Section 11 Schools Audit for the academic year 2020 - 2021 was scrutinised as part of the evaluations, which was completed by 276 school and educational settings.

Change Grow Live	Barnardos	Compass (School health)		
Canning Court Care Home: BUPA	Galanos house Care Home: Royal British Legion	Coalpits Supported Living: Turning Point		
Key 2 Future	St Basils	Together UK	Young Foundations	Key Transitions
Coventry & Warwickshire Partnership Trust	University Hospital Coventry & Warwickshire	George Eliot Hospital	South Warwickshire Foundation Trust	
Warwick District Council	Rugby Borough Council	North Warwickshire District Council		
Probation	Warwickshire Police	Warwickshire Children's Services	Social Care and Support	

Figure 2: Agencies that completed the Self- Evaluation

CASE FILE AUDITS

To enable the multi-agency case file audit, Warwickshire Safeguarding identified 15 cases each for children and adults. These came from a variety of teams and not specifically from only safeguarding teams, to ensure a full reflection of practice. This approach was recommended following an evaluation of the first strategic thematic review. The cases identified had been open and active within the last 2 years and had not been subject to a CSPR or SAR.

A case file audit tool was developed to support the audit and cases were shared with partner agencies for them to undertake their own case file audit for those cases which may be known to them from the selection provided.

121 audits were completed and were submitted by a range of statutory agencies which included Children's Social Care, Social Care and Support (formerly Adult Social Care), Warwickshire Police, the George Eliot Hospital, South Warwickshire Foundation Trust, University Hospital Coventry and Warwickshire, the CCG and Coventry and Warwickshire Partnership Trust. Agencies completed their own quality assurance processes to ensure any internal learning was captured. The WSP Business Team evaluated the responses in line with the priorities of the thematic review.

Lessons from Published Safeguarding Reviews

There have been a number of safeguarding adults reviews and child safeguarding practice reviews that have been completed and published on the WSP website. The recommendations, key findings and themes for those reviews currently published have been considered as part of this review process.

FEEDBACK FROM PRACTITIONERS, SERVICE USERS AND THEIR FAMILIES

A range of different approaches was utilised to obtain feedback from practitioners. An online survey was created that staff were able to complete anonymously. All agencies that had been approached to complete the self-evaluation were asked to request that their staff complete the survey; 188 returns were completed by staff from a range of organisations *(Figure 3)* including both statutory and voluntary organisations, local councils, service providers and early years settings. In addition, 15 members of staff were spoken to for a more in-depth consultation, via the telephone and Microsoft Teams interviews.

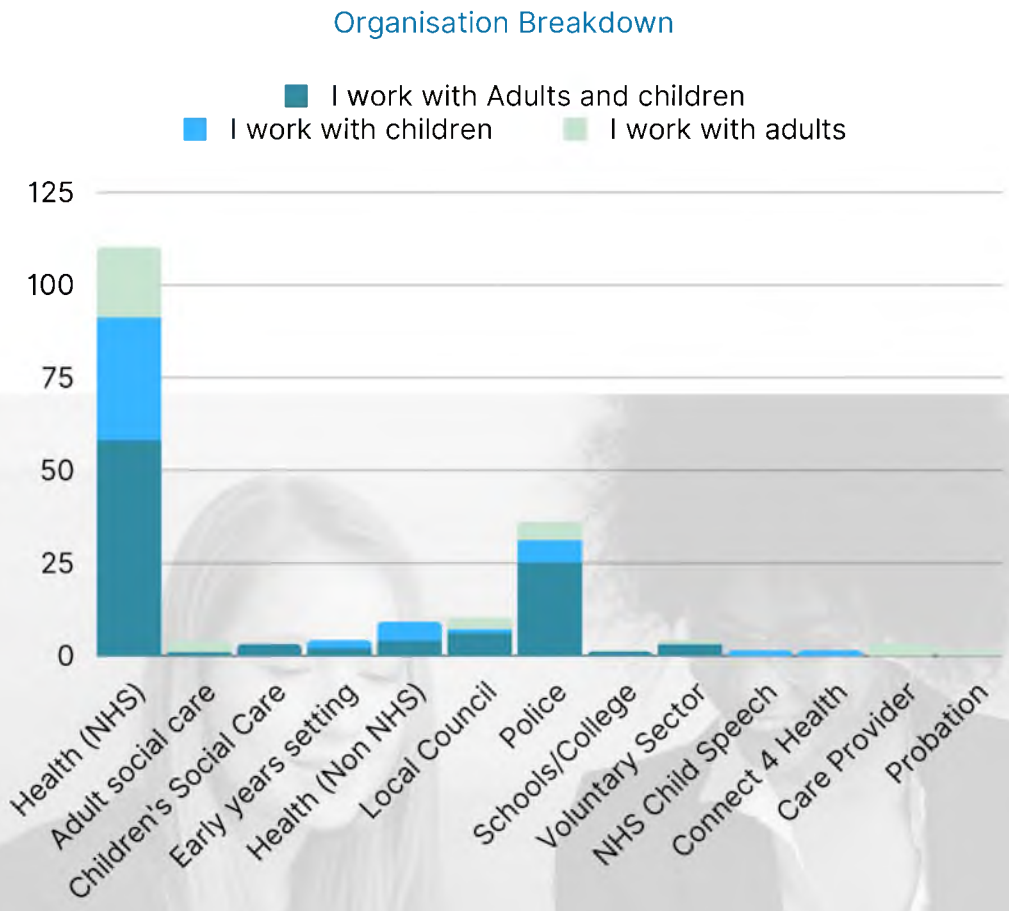


Figure 3: Breakdown of responses by organisation

As part of this process, it had been hoped that the opportunity to consult with children, young people and adults with care and support needs, and their families, would be created to add to the findings of this thematic review. However, it became apparent that identifying those people that would be willing to share their experiences would be difficult especially due to the need to discuss their experiences of safeguarding processes and procedures. Opportunity has, however, arisen through the completion of both Child Safeguarding Practice Reviews and Safeguarding Adults Reviews to speak with the individuals involved, and their families, and where the themes of this thematic review have been discussed these have been considered to help inform this wider review. In addition, 6 case file audits have been reviewed by the Business Team to further understand the journey of the child/adult through the safeguarding intervention. Findings from these individual audits have been included to understand their journey and experience.

KEY FINDINGS: LEADERSHIP AND ACCOUNTABILITY

"We display posters around the home the name of the person responsible. All staff are aware of who is the safeguarding lead"

1. Self-Evaluations

The self-evaluations received from partners indicated that leadership systems reflect the importance of safeguarding with 87% of agencies stating that they have a named safeguarding lead, 83% of these leads have received safeguarding training & 74% stating the leads have safeguarding responsibilities specifically within their job descriptions. Agencies identified a range of methodology in which they promote the details of the safeguarding leads.

"We actively promote a Safeguarding Culture ... training on Vulnerability and Safeguarding to many cohorts of police officers, from student officers, to experienced detectives at all ranks"

"We hold a weekly 'Safeguarding Surgery' for any staff member to attend to discuss, learn, plan, safeguard, make decisions etc"

Partners indicated that whilst they may not have named leads for all the specific safeguarding areas, the safeguarding lead will hold overall responsibility for these areas and will have completed specific training.

99% of schools and educational settings advised that their lead DSL is a member of the senior leadership team, with 82% of these settings advising that DSL responsibilities are explicit in job descriptions of the lead DSL and all deputy DSL's in the school/setting.

76% of Chairs of Governors and the governor with safeguarding responsibility have also received safeguarding training. The Schools' audit also identified that there is an average of 5 DSL's with up-to-date safeguarding training per setting.

There was inconsistency in experience and understanding between agencies in respect of the Safeguarding Adult Reviews (SAR's) and Child Safeguarding Practice Reviews (CSPR's) processes. Those statutory agencies that are more frequently involved had very clear processes in place to ensure information from the reviews is disseminated to staff, whereas those agencies that may not be so involved had limited understanding of the process. They also indicated that they were not always aware of the learning from reviews that may be relevant to their service; however this was acknowledged by some agencies who have put processes in place to ensure learning from reviews is embedded which indicates one immediate benefit from the self-evaluation process.

> *"Going forward we will seek to look at future SAR's and CSPR's to look at the impact of these procedures and how they are actually improving practice."*

Partners were also asked about the lesson learned and 7-minute briefings that are produced by the partnership as a result of the reviews, with 70% indicating that they have clear processes in place to ensure the briefings are utilised.

> *"We do not currently use WSP's 7-minute learning briefings; however, we have now seen these on the Warwickshire Safeguarding website and will incorporate these into our reflection and learning processes."*

A number of agencies indicated that they utilise the briefings in team meetings and training as well as signposting staff to the briefings using their intranet and newsletter processes.

2. Case File Audits and Lessons from Published Reviews

Whilst case files do not hold information in respect of practitioner knowledge in respect of leadership and the role of DSL's the audits did consider whether management approval was appropriately sought in respect of decision making in reference to the outcomes of referrals. 18% of responses answered this question indicating that there was evidence that referrals had been received in their files, of those completed 4% indicated that the responses were 'Outstanding' with one return stating that *"the referral has clear and well-articulated management oversight"*; 81% of responses also indicating that management oversight was 'Good'. 18% of audits completed indicated that the responses were either 'Requires Improvement' or 'Unsatisfactory.' The areas identified include a lack of clarity for basis of decision making, delay in decision making which resulted in next steps falling out of statutory timescale requirements and poor recordings.

Warwickshire Safeguarding Partnership has responsibility to oversee the completion of Child Safeguarding Practice Reviews and Safeguarding Adult Reviews, to publish the reviews and findings on their website and to ensure that recommendations and actions are addressed and the impact on policy, procedures and practice is monitored moving forward. It is clear from this thematic review, however, that not all agencies and practitioners are fully aware of the findings and learning from the reviews, especially those who may not be directly involved and therefore the opportunity for wider learning may be becoming lost.

3. Feedback from Professionals

Of those practitioners that completed the anonymous online survey, 85% stated that they are aware of who their organisations designated safeguarding lead is. 60% also advised that they are provided with information and learning from local CSPR's and SAR's with a range of methods being utilised. *(Figure 4)* In addition to being provided information in briefings, newsletters, supervision and team meetings practitioners commented that they do their own research in respect of reviews, use the WSP website and find information on their intranet systems.

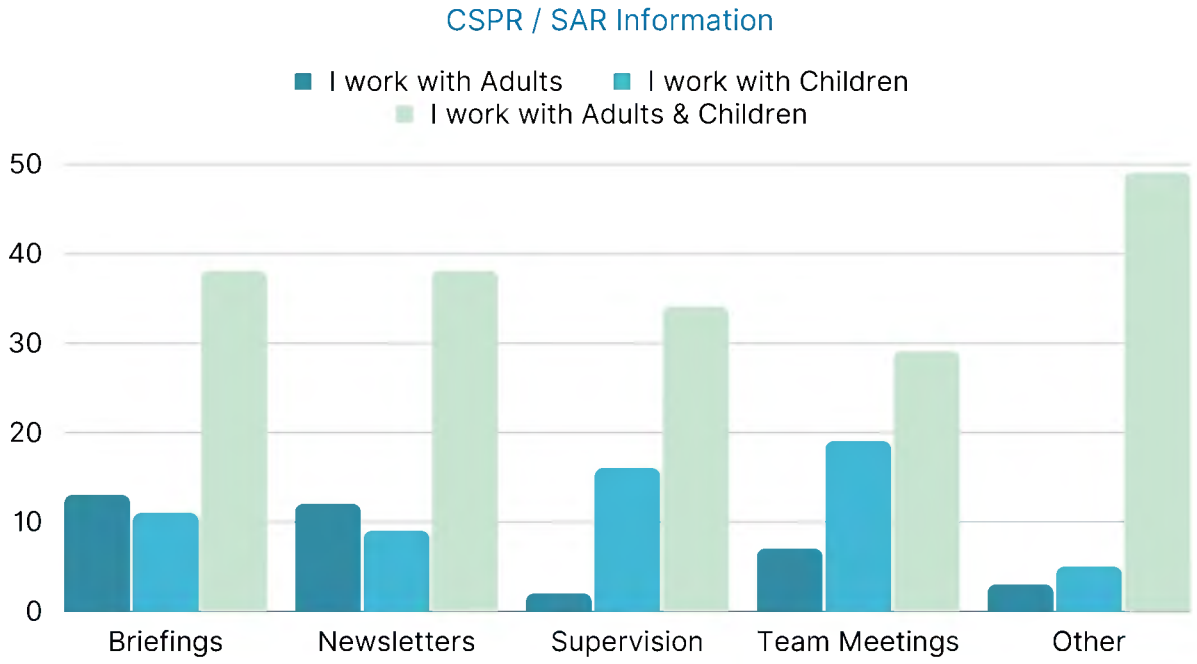


Figure 4: Methods used to provide safeguarding reviews information

When asked to specify the learning they can recall from these reviews, comments varied including important learning such as;

> *"Identifying which organisation should take the lead whom have authority to act and what collective support supporting agencies can give, instead of arguing who is taking ownership."*
>
> *"Thinking family first and the voice of the child being paramount."*
>
> *"How important it is for practitioners/professionals to work closely together and share information appropriately to provide the support a child and family needs"*

Other responses were less clear with a number stating that whilst they are provided with information about learning they couldn't recall what that was, and other comments seeming to be misaligned to the role of safeguarding reviews which may indicate a lack of understanding of their role and purpose within some agencies. This finding may be expected, as the self-evaluations identified a range of understanding of the role and purpose of safeguarding reviews by partners and this lack of clarity may well be directed towards staff.

In respect of practitioner awareness of the lessons learned and 7- minute briefings produced following a review the responses were disappointing *(Figure 5)* with only 20% of responses indicating that they are aware of these briefings; this is despite 70% of partner agencies stating within their self-evaluation that they have clear processes to disseminate this information to their staff.

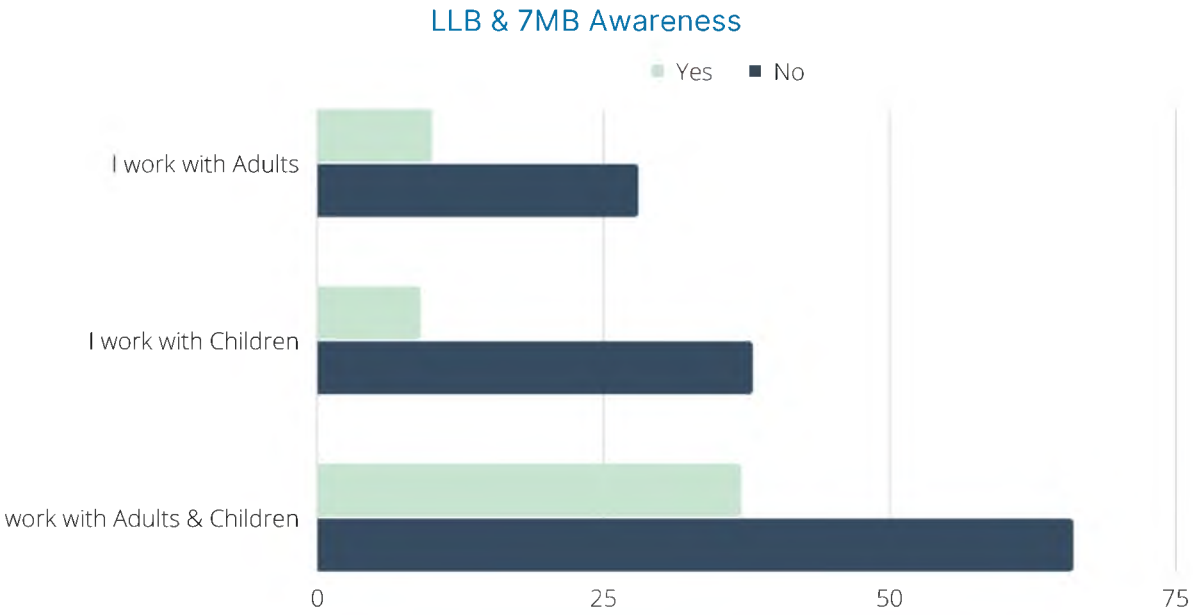


Figure 5: Practitioner awareness of briefings

During the conversations with practitioners, it was clear that they were aware of who the organisations designated safeguarding lead was and how they would contact them if required, however, learning from reviews and briefings were less widely know about. Some practitioners commented that they had heard of the reviews but didn't really know where they could access them, others were not aware that they existed but felt they would be useful to be signposted to. Those consulted with included a number of staff who have a responsibility for the delivery of safeguarding training, and they had not accessed the briefings, nor had they considered reflecting on the findings of local safeguarding reviews to reflect upon within their training delivery.

4. Summary of strengths and areas for improvement

Strengths identified	Areas for improvement
• 83% of these leads have received safeguarding training • 74% state the leads have safeguarding responsibilities stated specifically within their job descriptions • Agencies identified a range of methodology in which they promote the details of their safeguarding leads	• Inconsistency in experience and understanding between agencies in respect of the SAR and CSPR processes, with practitioners indicating limited awareness of learning • Lack of awareness of LLB and 7MB's·

Figure 6: Summary of strengths and areas for improvement

KEY FINDINGS: POLICIES, PROCEDURES AND PROTOCOLS

1. Self-Evaluations

All agencies that completed the self-evaluations indicated that they have a suite of policies and procedures in respect of their safeguarding practice with review processes in place to ensure these are kept up to date. It was also indicated that the majority of agencies seek to ensure that these policies are introduced to staff during the induction process. Over 90% of schools and education settings indicated that they have policies and procedures in place in respect of child protection and staff behaviour (code of conduct) and that a mechanism has been established to ensure that all staff, including temporary staff and volunteers, have read and understood Part 1 of Keeping Children Safe in Education.

Some agencies evidenced processes they put in place to ensure that their staff's knowledge remains up to date, such as dedicated staff having responsibility to ensure there is a focus on safeguarding policies and legislation, and other advising of a range of communication methods, such as briefings, blogs and updates on intranet provision. A large number of returns, however, did not provide information of how they ensure their staff knowledge of policies and procedures remains current once the initial indication period has come to an end.

The self-evaluation tool asked questions about a number of specific policies and procedures, one of which is the WSP Escalation Protocol. 50% of agencies indicated that they are aware of this protocol and that it was either referred to in their policies and procedures or it was included in their training offer. The responses provided by agencies, however, indicated a range of understanding of the process and when it should be activated, for example the following comments are in response to a question about escalation;

> *DSL is aware of procedure and escalation process, if there were or are concerns would speak directly to the Warwickshire LADO, Staff were also informed and given LADO details"*

> *"If a safeguarding concern meets the safeguarding team or LADO threshold, then we would submit a referral"*

A large number of agencies also left this section blank, which may indicate a lack of awareness of the process. The schools and education audit did not ask specifically about escalation, which may be something, moving forward, that may be beneficial in future audits.

Similarly, there was a range of awareness of thresholds; with statutory partners having a good understanding whereas other agencies acknowledged that they are not aware of the Spectrum of Support guidance, or similar, , however, a number indicated that as a result of this activity they were reviewing their processes and would be issuing guidance in respect of thresholds.

The self-evaluations for those agencies that worked predominantly with adults identified an awareness of self-neglect and associated policies and procedures; those agencies that worked with children indicated that they had an understanding of referral procedures if there were concerns about self-neglect within a family with whom they were working with. Statutory agencies also indicated that they had policies and procedures in place in respect of children who move across authority borders, when a child or adult is not bought to appointments and the think family approach.

2. Case File Audits and Lessons from Published Reviews

16% of the cases audited indicated that escalation was a factor, with 61% describing practice as 'Good' in this respect. It was noted, however, that the responses describe a difference in interpretation of the meaning of escalation with only a small number of these responses indicated that escalation was required due to disagreement between agencies. Where this was evidenced the returns suggested that concerns were discussed, with one return stating "Documentation refers to social worker challenging safeguarding lead at hospital in relation to delay in reporting concerns."

11% described practice as 'Requires Improvement' with returns indicating delays in escalation which resulted in unnecessary delays and 28% described practice as 'Unsatisfactory' indicating that escalation was not considered, where the auditor felt this would have been appropriate, and the formal escalation process was not activated. It was noted that no audit indicated that the formal escalation process was utilised.

66% of those audits that indicated that service user may be at risk of abuse or neglect indicated that the concern was identified, and urgent safeguarding actions were taken. The auditors were also asked to rate recordings in respect of concerns or suspicions of abuse, and to indicate whether expected standard were met. Out of those audits that identified this area 72% indicated that the standards were either 'Outstanding' or 'Good' with evidence that practice was evidenced by clear and accurate recordings which supported timely decision making. Where audits indicated 'Requires Improvement' or 'Unsatisfactory' comments indicated that there was a lack of understanding, analysis and curiosity in respect to the situation. There was also an indication of sparse or incomplete recordings.

Auditors indicated whether there was evidence of knowledge of some specific policies, procedures and protocols which are indicated in the tables below.

	Outstanding	Good	Requires Improvement	Unsatisfactory
Where Self-Neglect was a factor	0%	57%	14%	28%
Where Strength-Based practice was indicated	0%	84%	5%	10%
Where 'Think Family' was a factor	5%	80%	5%	10%

Figure 7: Table for Social Care and Support

	Outstanding	Good	Requires Improvement	Unsatisfactory
Where Restorative Practice was identified	0%	57%	38%	5%
Where Moving Across Local Authority Borders was identified	15%	77%	8%	0%
Where 'Think Family' was identified	0%	61%	26%	13%

Figure 8: Table for Children's Services

A number of published reviews have identified common themes that relate to the interpretation and use of policy and procedure. The full reviews can be read on the WSP website; below is a summary of relevant findings:

EXAMPLE: Use of Appropriate Escalation

PRADA & JORDAN: When a number of professionals have a collective view that a child's educational needs are not being met there needs to be robust and timely challenge in the form of a formal escalation to the relevant agency. This challenge should include when local policy and procedure do not appear to be working in a child focused way.

JAMES: The need to undertake a comprehensive review to understand what the barriers are to professionals using the escalation process and why it is so under used?

EXAMPLE: Protecting Children who move across Local Authority Borders

ALICE & BETH: Where a family moves between areas the new authority and relevant partners need to be informed. A decision needs to be made on when this is undertaken if the move is believed temporary according to the risk, but where there is an ongoing assessment or investigation this should be undertaken as soon as knowledge of the move is received.

EXAMPLE: Consideration of 'Think Family'

AMY: When a new adult joins a family, who is open to Children's Services and are deemed to be vulnerable, partner agencies need to assess the likelihood of risk of significant harm posed by that person to the child/ren in that family.

EXAMPLE: Understanding and Use of Thresholds

JACK: There is a lack of clarity in the MASH about the threshold for dispensing with parental consent for lateral checks with other agencies for children resulting in missed opportunities to assess children who may be at risk of harm.

JAMES: The need to develop systems and processes to identify those young people with highly complex needs and at the greatest risk so that service responses can be flexible and if necessary, fast tracked to respond effectively to unmet need

PRADA & JORDAN: If parents are resistant to professional contact which is intended to support a child's needs (health, physical, intellectual, emotional, social or behavioural) the matter should be escalated or referred to the next level, with a follow up seeking an outcome.

3. Feedback from Professionals

Practitioners indicated which policies and procedures that they are aware of through the online survey as indicated in *figure 9*.

Practitioners indicated that the most common method for sharing polices, and procedures was through the use of the internet/intranet, however staff handbooks were also popular with agencies that work with adults. Newsletters and contact with safeguarding leads were also cited as methods used to share this information, as was use of the WSP website.

58% of total respondents indicated that they are aware of the WSP Escalation policy, with those agencies that work with children, or children and adults, seeming to have a greater understanding than those that work solely with adults. The 'Think Family' document was less well known with only 27% of all respondents indicating that this is a document that they are aware of. Similarly, for staff that work either solely with children, or with children and adults, there was a relatively small number that suggested they were aware of policies in relation to thresholds to services; this was, however, reflected by the varying responses made in the self-evaluations in this respect.

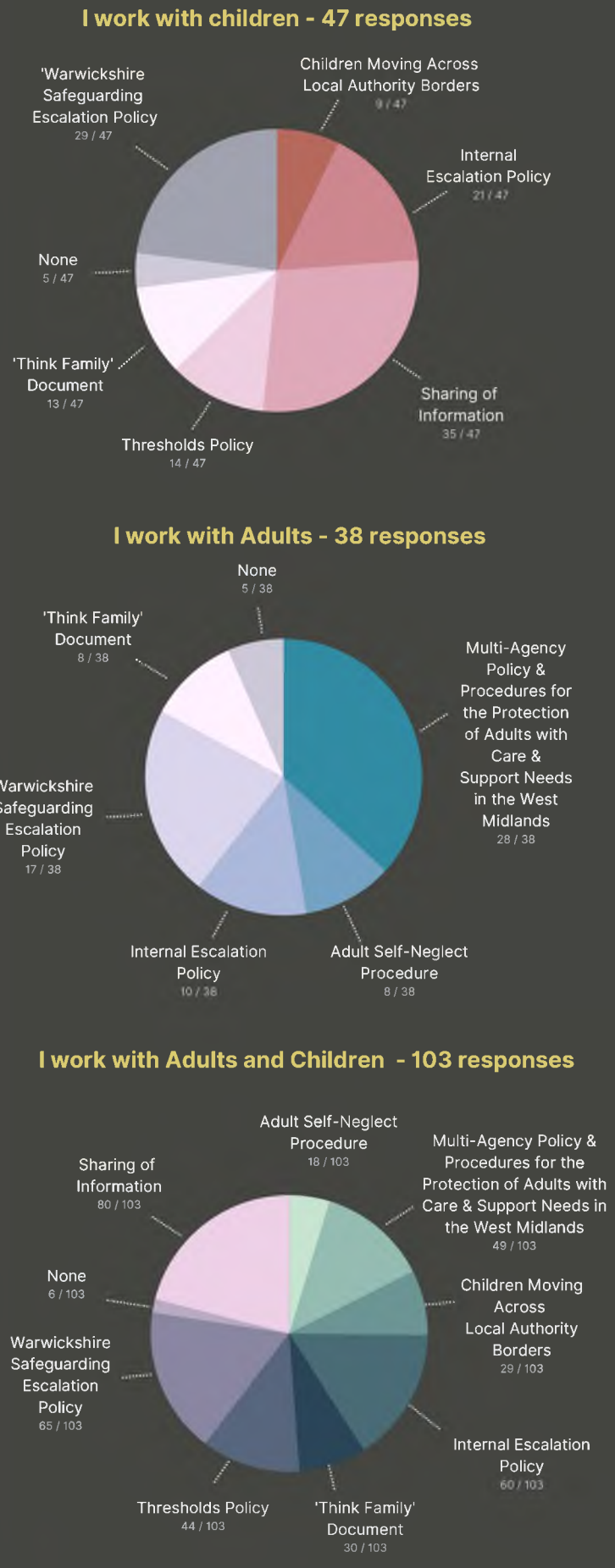


Figure 9: Practitioner Policy and Procedure Awareness

The practitioner consultations also reflected the findings of the survey with an indication that policies and procedures were made available via website and agency intranet services, in addition staff suggested that policies and procedures are discussed in supervision and team meetings. When asked about specific policies there was a limited awareness of the escalation process, with those spoken to using their judgement as to what the process may be rather than having a secure knowledge.

> *"Am I confident that I know what to do? – no, I'd probably start talking up the scale, but I don't know the process."*

Others spoke of an unease of using the process,

> *"It's the last resort isn't it, really. I don't think I would feel very happy using it."*

4. Summary of strengths and areas for improvement

Strengths identified	Areas for improvement
• The majority of agencies advised that they have a suite of safeguarding policies and procedures • Range of methods used to share safeguarding policies and procedures; newsletters, intranet and handbooks	• Lack of evidence of processes that are in place to ensure staff awareness remains up to date • Limited awareness of the WSP Escalation Protocol • Limited understanding, by practitioners, of what the Escalation Protocol is and when it should be activated • Inconsistency in understanding of Spectrum of Support and thresholds • Self-evaluations advised of knowledge of policies and procedures in respect of self-neglect, 'Think Family' and 'Children Moving Across Authority Borders'; however, staff survey and consultations suggested limited understanding and awareness by practitioners

Figure 10: Summary of strengths and areas for improvement

KEY FINDINGS: RECRUITMENT AND SELECTION

1. Self-Evaluations

All agencies that completed the self-evaluation advised that they have stringent recruitment and selection processes in place which included ensuring that professional and character references were provided, and appropriate DBS checks being completed dependent on the nature of the role. It was noted, however, that some responses indicated that they charge staff for the cost of the DRB check, which may prevent capable people for potentially applying for the role. There was also evidence that potential employees are checked for suitability through consideration of experience and qualifications; with many agencies having developed their own processes for safe recruitment.

The schools and education settings audit indicated that, on average, 4 leaders/governors per setting have undertaken safer recruitment training with 98% indicating that at least one interview panel member had undertaken this training. 100% of these settings also indicated that they include at least one question in respect of safeguarding during the recruitment process. 98% also indicated that relevant DBS checks were completed before commencement of roles.

Agencies described a variety of induction processes, usually ranging from a period of 4 to 6 weeks, which included mandatory safeguarding training as a very minimum with some agencies indicating that specific training took place during this time such as PREVENT and domestic abuse awareness training.

2. Case File Audits and Lessons from Published Reviews

Recruitment and selection was not covered within the case file audits, nor was identified as a theme within published reviews.

3.Feedback from Professionals

The majority of practitioners confirmed, via the online survey, that DBS checks were completed prior to starting their employment however, interestingly, 17% indicated that they did not know whether a DBS had been completed or not. Inductions were also provided to the majority of new staff, however the experience of this differed between services.

This range of experience of induction processes was also identified within the staff consultations. Some staff spoke of very clear induction processes with induction packs being provided, whilst others indicated that the induction process as "hit and miss". One staff member indicated that whist there is an organisational induction process safeguarding does not feature as part of this and this is something that is separate to the induction process. The staff spoken to also confirmed that they had appropriate DRB checks in place with their organisation having systems to ensure that these were renewed in a timely fashion.

4. Summary of strengths and areas for improvement

Strengths identified	Areas for improvement
• All agencies have processes in place to complete necessary checks before commencement of employment	• Inconsistency with practitioners' experience of induction processes

Figure 11: Summary of strengths and areas for improvement

KEY FINDINGS: STAFF TRAINING AND DEVELOPMENT

1. Self-Evaluations

The self-evaluation asked a number of questions about specific training that has been provided to staff. Information about these areas of training was requested as these where specific areas that had been identified through local safeguarding reviews as areas that need more training focus and included:

- working with customers/parents/carers who may be aggressive, controlling and disruptive,
- identifying, assessing and appropriately addressing the emotional abuse of children,
- spotting the signs that children are being neglected,
- understanding and working with those adults who self-neglect and
- professional curiosity and disguised compliance

A number of agencies advised that they offer staff training in respect of conflict resolution and conflict training; however, a large number of responses left this section blank. 50%, of relevant agencies, indicated that training is provided in respect of identifying neglect in children with a similar number stating they also provide training in respect of identifying the emotional abuse of children; much of this being delivered through child protection training.

Agencies that feel staff have the necessary training and skills to work with adults who are self-neglecting, with 19% advising that training has been provided to staff in this area. Some agencies commented that whilst training was offered, it may not be at the level that is required by their staff:

"We have bite sized training and acknowledge that vulnerable adults and self-neglect have been identified as an emerging trend/issue; therefore, their training on this issue could be more specific"

68% of agencies indicated that training is provided in respect of professional curiosity and disguised compliance, with agencies also utilising team meetings and supervision to further consider these areas.

"The Safeguarding team shares knowledge and learning during regular Peer meeting to further enhance and enrich the support provided for practitioners which is 'live' and meaningful"

The audit of schools and education settings provided different information about the training for staff working within the settings. The audit evidenced that high numbers of school staff, including teaching staff, auxiliary staff, governors, and volunteers, had complete their annual safeguarding training. It also identified that that over 80% of this training covered a wide range of areas including child criminal and sexual exploitation, definitions of abuse and neglect, domestic abuse, peer on peer abuse and recording safeguarding concerns. Lower numbers were indicated in the areas of private fostering, mate crime and trafficking.

The self-evaluations indicated that the majority of agencies complete annual appraisals, with a number evidencing how these link through with their supervision processes. Agencies also indicated that their training provision is reviewed through the appraisal process as well as consideration for professional development.

2. Case File Audits and Lessons from Published Reviews

The audits indicated that 61% of responses that identified that the emotional abuse was a factor of the case were of an 'Outstanding' or 'Good' standard. The audits indicated good recordings in respect of identifying emotional abuse of children, the impact and the plans to offer support.

> *"Clear reference to the emotional harm that can be caused to children from witnessing and experiencing domestic abuse between parents, that can go onto have a detrimental impact on all areas of their global development."*
>
> *"The file shows clear evidence that emotional abuse was identified, assessed and addressed."*
>
> *"There is recognition of attachment and trauma and consideration how this has impacted on young person's processing and cognitive ability."*

The case file audits asked the auditors to consider whether there has been professional curiosity, and this is clearly recorded in the case file. Of the responses received 6% were considered to be 'Outstanding', 67% 'Good', 36% 'Requires Improvement' and 4% 'Unsatisfactory.' Where auditors indicated practice fell below required standards they identified a lack of exploration, accepting information at face value and a number commented that professional curiosity was not reflected upon within supervision;

> *"On one attendance there was no evidence of professional curiosity and account for injury was taken at face value"*
>
> *"Supervision does not demonstrate professional curiosity or reflection, and is just a review of the plan, it is very brief, it therefore raises question about the space to offer professional curiosity."*
>
> *"Customer not spoken to alone. Kitchen observed as unclean, but account given over phone accepted. Accounts that help being given by other family members accepted and their feedback and corroboration not sought - they had previously described concerns and given a different view."*

A number of published reviews have identified common themes that relate to the use of training. Below is a summary of relevant findings:

EXAMPLE: Working with Customers/Parents/Carers who may be Aggressive, Controlling and Disruptive

AMY: All front facing staff in Health and Social Care, including reception staff, should receive training and be able to identify potential indicators of coercive and controlling behaviour.

EXAMPLE: Identifying Abuse and Trauma

JACK: School and other agencies missed possible signs of trauma resulting from adverse childhood experiences and did not work together to develop plans to address these and support Jack.

EXAMPLE: Professional Curiosity

CHARLIE: Professionals should exercise professional curiosity and healthy scepticism when investigating and/or assessing concerns for children and their families and their histories - to establish all the facts and accounts around potential safeguarding incidents and to explore any discrepancies or missing information.

AMY: Children's Services are encouraged to use information from all sources and to use 'healthy scepticism and cautious optimism' in making assessments in decisions concerning families. This approach should be reviewed in supervision.

ALICE & BETH: On reflection at the practitioner's discussion, professionals who had been involved in the case felt that from this case they would exercise a more 'healthy scepticism' and explore the hypothesis that a parent may have caused the harm, to be able to develop it further or discount it.

3. Feedback from Professionals

The practitioners that completed the online survey provided information about the training that they have received in the last 3 years. (*Figure 12)*

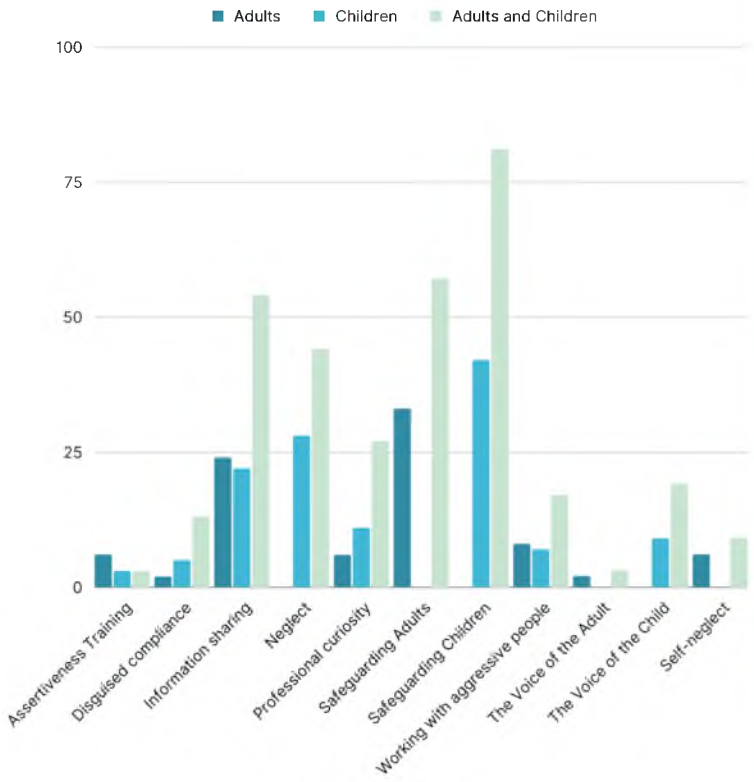


Figure 12: Training

This information therefore indicates that there is a low update of training in the areas identified despite the self-evaluation indicating that this is something that is offered.

The survey asked staff to indicate what additional training they thought would be beneficial. Training in making a referral to social care and thresholds was one area that came up from a majority of responses. *(Figure 13)*

Figure 13: Referrals / Thresholds

"Training on how to get MASH to actually accept a referral would be great. No point teaching us to recognise abuse when the referrals are constantly turned down."

"What is the criteria for a referral, as it keeps changing and is dependant also on the Social Worker and what they deem a risk"

"Writing a referral to meet thresholds"

"Working Processes within the MASH and how the referral systems work"

"how to make a safeguarding referral"

""a clearer idea of what actually happens and should happen once a safeguarding referral is made. Who's involved etc.. why and how things happen".

In addition to this responses indicated that practitioners would like more training in professional curiosity, dealing with aggressive customers, case studies and working with those who self-neglect were also popular answers. A number of responses indicated there would be benefit from having regular and consistent multi-agency training as opposed to single agency training;

> *"I think any training where multi-agencies are all together rather than training being delivered to one agency at a time is beneficial. Other agencies will have questions and ideas that may have relevance to my area of business but would not necessarily seem relevant at the time. By having multi-agencies in the room of people at the "ground level" rather than managers it will also help forge relationships moving forwards and mean that everyone is on the same page"*

The staff that were spoken to indicated that they had accessed either adult or child safeguarding training when they started in their role, but very few were able to identify any more specific training that they had received. None had attended training in working with people who may aggressive or controlling or in professional curiosity. One staff member spoken to had the responsibility for developing training for their service and indicated that the offer had greatly reduced since Covid 19, and it was only within recent weeks that the organisation was looking to re-start the training provision.

Over 80% of those staff who completed the online survey indicated that they had annual appraisals, which was also confirmed by everyone spoken to within the staff consultations, who commented that development and training was reflected upon during appraisals and if it was determined that training was not up to date this would be addressed.

4. Summary of strengths and areas for improvement

Strengths identified	Areas for improvement
• Agencies offer a range of safeguarding training to staff • Agencies complete annual appraisals which reflect on staff development	• Training that links to specific learning from reviews has not always been made available • Staff consultations and surveys indicated limited training being offered in areas such as; professional curiosity. Working with aggressive and controlling parents and carers and capturing the voice of the child/adult • Staff indicated that there is a lack of training in respect of making a good referral • Staff indicated that there is a lack of multi-agency training - with training delivery usually being single agency

Figure 14: Summary of strengths and areas for improvement

KEY FINDINGS: COMPLAINTS, ALLEGATIONS AND WHISTLEBLOWING

"We have developed a variety of ways to gather feedback from the children and families we work with, via questionnaires, or an electronic app, in order to facilitate gathering honest opinions, whether they are good or bad. This feedback is used to inform and improve our practice, to ensure that the right support is provided at the right time in the future."

1. Self-Evaluations

Within the self-evaluations agencies provided evidence of their complaints procedures and processes which aimed to ensure there is an accessible and transparent process in place. A number of agencies commented that their complaints process was a regulatory activity. Agencies also described methods used when compliments were received to ensure that their staff and services were aware and could learn from good practice. 53% of agencies that work with children took the opportunity to evidence that they have 'child-friendly' processes in place to ensure that the voice of the child is heard.

A small number of agencies also described the processes that are in place when complaints are received to ensure that learning is fully understood and disseminated.

> *" Family and Friends surveys are carried out across all divisions of the organisation and are reported on accordingly. Compliments as well as complaints are followed up appropriately to improve practice. Patient Involvement and Engagement events are widely published, including on social media to engage the Warwickshire community."*

Similarly, agencies evidenced policies and procedures that they have in place to support staff allegations and whistleblowing. This information was made available widely utilising websites, intranet services and 'Freedom to Speak Up Guardians.' Surprisingly, however, a small number of agencies did not complete this section, which could indicate that they do not have a complaints, allegations, or whistleblowing process in place. The majority of agencies that left these sections blank were service providers.

2. Case File Audits and Lessons from Published Reviews

Complaints, allegations and whistle blowing was not covered within the case file audits, nor was identified as a theme within published reviews.

3.Feedback from Service Users / Professionals

The online survey indicated that staff have a good awareness of the internal complaints and whistle blowing processes for their organisations, although some responses suggested that whilst staff are aware that the policies and procedures exists they are not aware of the full processes that are in place. There was also limited evidence that staff are aware of any changes that have been made as a result of complaints.

4. Summary of strengths and areas for improvement

Strengths identified	Areas for improvement
• A number of agencies indicated they have information in 'child friendly' styles and suitable for adults with care and support needs in respect of making a complaint • A number of agencies indicated that they utilise a range of methodology to ensure the voices of their customers are heard in respect of quality of services • Practitioners indicated a good knowledge of complaints processes	• Practitioners indicated that they rarely are made aware of the outcomes/learning following complaints

Figure 15: Summary of strengths and areas for improvement

KEY FINDINGS: INFORMATION SHARING, COMMUNICATION & CONFIDENTIALITY

"Staff do participate but we are not always invited, and this could be improved. Issues have been raised in relation to extending the invites and acknowledging we have a part to play."

1. Self-Evaluations

The self-evaluations indicated that agencies have policies and procedures in place in respect of information collection and sharing, with a number highlighting the policies have information about when consent is, and isn't required, to share information. A number of agencies referred the Inter-Agency information Sharing Agreement and indicated that staff are provided with training in respect of information sharing. Evidence was also provided indicating that confidential information was stored securely and within GDPR guidance. A small number of responses suggested that paper copies of information are still being used, however there was indication that processes are in place to ensure the information is securely stored.

Agencies also indicated that they have processes in place to ensure that staff are aware of the pathways and procedures for making timely referrals to social care. A number of agencies described using flow-charts as a visual tool to support staff with this activity. In respect of case conferences, multi-agency meetings and reviews the responses indicated that they would attend meetings, if invited, and had processes in place to receive and store minutes. A number of agencies, however, did indicate some difficulties in being invited to meetings in a timely manner, and insufficient information about the details of the child or adult, which caused delays.

Agencies, that work with children, provided information about the processes that are in place to ensure information is shared when a child moves across local authority boundaries; with references being made to policies and procedures and liaison with counterparts in neighbouring authorities.

Agencies were also provided with the opportunity to reflect on the use of history in their assessments to enable practitioners to understand whether there may be any impact on current circumstances. The majority of agencies provided statements that indicated that they felt confident that history was used within working with customers, with agencies providing a range of methodologies in which this is managed. Some agencies have access to electronic systems that ensure chronologies are completed, whereas others have this as part of their assessment and planning policies and procedures; with one agency indicating that the use of chronologies has been the recent subject of a deep dive audit review which has resulted in recommendation and actions to improve and embed practice.

> *"We are routinely given a short amount of notice of safeguarding meetings. In June we completed a safeguarding audit with 28 identified CYP. With 14 of those identified individuals we were given less than 7 working days' notice of a safeguarding meeting and on one occasion we received no invitation at all, only finding out about the case when we received the conference minutes."*

> *"In July we had 24 occasions when our central administrative team had to go back to request further information as invitations being sent through regarding safeguarding meetings were incomplete. This meant that we were not able to identify the correct child as we had not been provided with a fully name and D.O.B. In many instances we were purely provided with a surname and no other information. There is a considerable amount of time wasted whilst emails go back and forth , chasing information"*

The audit of schools and education settings indicated that over 90% of settings had processes in place to ensure records are completed in a timely fashion, that they are held securely and accessible to staff across the setting. The audit also provided useful insight into the transfer of confidential information between schools; with the information provided indicating that the majority of schools/education settings had clear processes in place to ensure the safe and timely transfer of information between schools. *(Figure 16)*

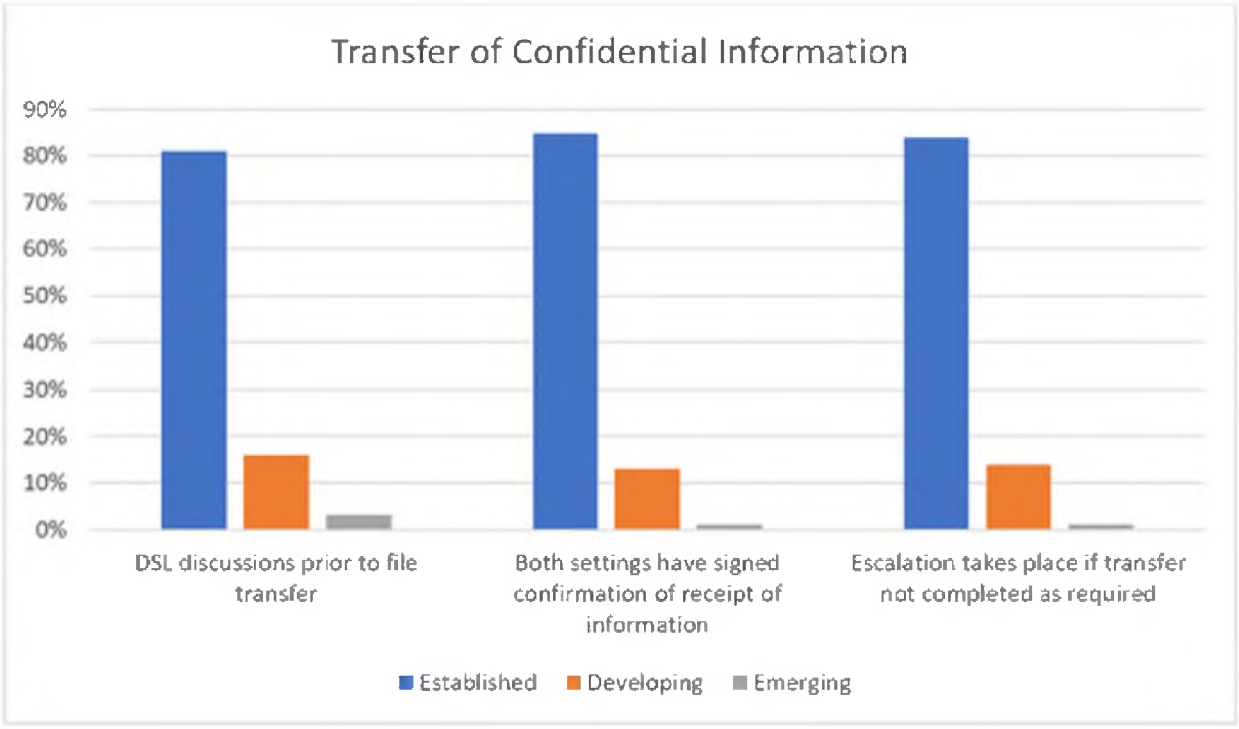


Figure 16: Transfer of Confidential Information between Schools

2. Case File Audits and Lessons From Published Reviews

Those case file audits that commented on information sharing indicated that this was generally of a high standard with 86% indicating the audits were either 'Good' or 'Outstanding' in this respect. These audits evidenced that information was shared across multi-agencies, where required, and referrals were made. There were a number of comments from auditors, however, that referrals were made but there was no evidence that feedback had been sought or received as a result. Where the audits identified that information sharing was not of a good standard the main reason given for this was delays in the information being shared which impacted on timely decision making and support.

The audits indicated that information sharing was also of a good standard within assessments with 84% of responses rating the standard as either 'Outstanding' or 'Good' with auditors indicating that the assessments had been completed with information being sought from multi-agencies and with this being well recorded. Where practice was not of such a high standard this was generally because information hadn't been sought from additional agencies and therefore lacking the depth of understanding of the situation and auditors also stated that information that had been shared was not fed through into assessments and plans. Once again, a number of audits indicated that there was a lack of feedback from agencies following the completion of assessments.

The audits also looked at the use of history and genograms with 52% of responses indicating this was of a 'Good' standard;

> *"Chronology details key events and meetings in relation to missing, strategy meetings, orders. The new chronology format in mosaic is being used"*
>
> *"The health professional conducting the CP medical took a detailed family history and a family/ medical history from the mother."*
>
> *"It is evident that chronology and history was considered within the context of current concerns and risks. The Child's Story Chronology is being used as per procedures and thorough genogram"*

28% indicating 'Requires improvement;'

> *"There is a chronology, but this is a list of actions that does not show impact, progress or outcome. There is narrative within the reports about the family's history, but this information is not included in the initial assessment completed. There is not one central place to understand this family's history and each report shares slightly more information, following feedback from healthy relationships sessions. I could not find evidence of a genogram."*
>
> *"I was not convinced in auditing the file that the relationship between parents was understood nor robustly challenged enough based on previous history"*

and 20% as 'Unsatisfactory;

> *"The recordings show throughout referral, assessment, supervision notes and closure that full family history was not known. There is no analysis as to what the history tells us about the functioning of the family or how this could have informed future outcomes."*
>
> *"The Chronology is empty. Genogram is complete although does not give any detail of paternal family."*

The audits looked, in some detail, in respect of the process of making and receiving referrals, the response to referrals and the quality of feedback received; the ratings, for which, have been reflected in the tables below. *(Figure 17, 18, 19, 20)*

How would you rate the response to the initial referral and was it managed effectively within agreed timescales?			
Outstanding	Good	Requires Improvement	Unsatisfactory
7%	75%	13%	5%

Figure 17

Those audits that identified outstanding or good practice indicated that referrals were responded to within appropriate timescales that were proportionate to the situation. Those audits that identified practice below expected standards indicated delays in response, some of which were against statutory timescales, and repeated referrals that resulted in no further action that the auditors felt were not appropriate decisions.

How would you rate the feedback provided to the referrer following their referral?			
Outstanding	Good	Requires Improvement	Unsatisfactory
2%	68%	12%	18%

Figure 18

All auditors commented, where they felt practice was 'Outstanding' or 'Good' that this was because the referrer was kept informed of the outcome of the referral and had an understanding of what the next steps would be. Where the auditors felt practice was either 'Requires improvement' or 'Unsatisfactory' this was because recordings did not evidence that feedback have been given, inappropriate advice in respect of referral routes was provided or that there was evidence that the referrer was chasing for a response as it had not been received.

It is evident that the concern decision making was timely, proportionate and well recorded			
Outstanding	Good	Requires Improvement	Unsatisfactory
7%	66%	17%	10%

Figure 19

It is evident that management approval had been sought in respect of decision making in reference to the outcome of the referral.			
Outstanding	Good	Requires Improvement	Unsatisfactory
2%	75%	17%	6%

Figure 20

A number of published reviews have identified common themes that relate to the use of information sharing, communication and confidentiality.

EXAMPLE: Information Sharing

JACK: The schools which Jack attended during this period did not consistently collate and share safeguarding and other relevant information both internally within their own organisations and externally when students move schools which means that students safeguarding, and welfare needs are not always met.

PRADA & JORDAN: Background information should always be provided from one school to another, or sought if not provided, about a child prior to a child being admitted on to the school roll.

EXAMPLE: The Importance of Using History

CHARLIE: The importance of completing chronologies in Early Help and Safeguarding/ Child Protection work to provide an overview, a valuable oversight of children's lives, and to help identify any emerging patterns of behaviour and recurring issues.

PRADA & JORDAN: Using and maintaining tools such as chronologies will enable sharing and mapping intelligence in a timely way across the professional network.

EXAMPLE: Making Good Referrals

PETER: It is important that where referrals are sent to other agencies that all relevant information is included, and they are of a quality to allow a full assessment

CHARLIE: When agencies make referrals to the MASH, they should ensure that the information included accurately and fully reflects the concerns of the referrer and the MASH should clarify any information that is not clear

3.Feedback from Professionals

71% of staff that completed the online survey indicated that they are aware of how to make a referral to social care. They were asked to describe the steps they would take to make a referral, which further evidenced that most staff have an appropriate knowledge of the process.

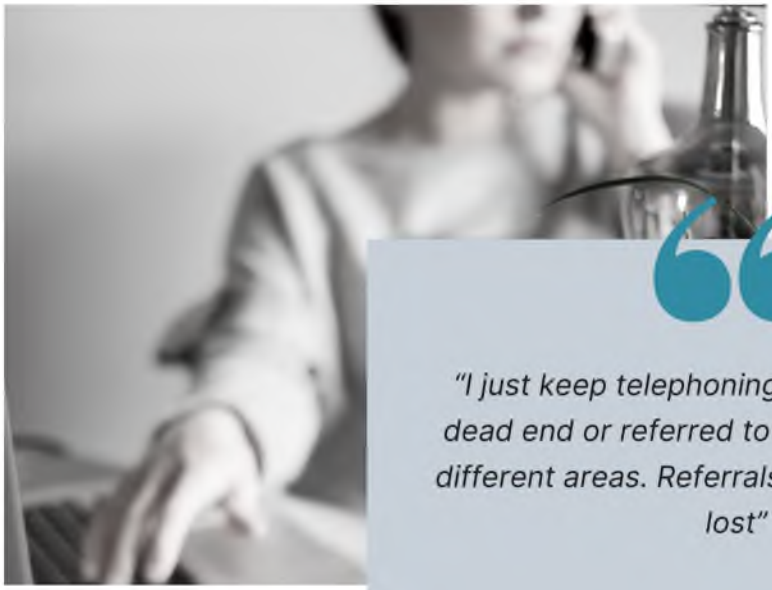
"Phone MASH, liaise with Safeguarding nurses and manager to ensure have followed procedure correctly and also refer to policies on the intranet"

"Discuss with Safe guarding lead if unsure. Complete a MASH referral, ensure parents/carers are aware unless this will put the child at increased risk."

"Speak to DSL and report my concern to them and the DSL would make the referral and feedback to me on the outcome. If I had not been informed of an outcome I would go to the DSL"

"Support worker raises a concern with line manager, concern is discussed & referral line called for some extra advice from the duty social worker, referral form is then completed (if needed) and submitted. Local safeguarding logs are completed and our support plans & risk assessments update."

The survey then went on to ask the practitioners what steps they would take to ensure the referral has been received and acted upon. A number of staff indicated that they would ensure they received written confirmation that the referral had been received and that they would make further contact if this was not received in a timely fashion. A number of responses also identified that they would utilise the Warwickshire Safeguarding Partnership Escalation Protocol if they felt the referral was not being acted upon appropriately. A number of staff commented that they would refer to policies and procedures. A number of responses indicated that it can be very difficult to receive confirmation that referrals had been received and also that they are not always made aware of what the outcome of the referral is so they do not always know whether there is a need to raise further concerns or escalate.



"I just keep telephoning but often meet a dead end or referred to different teams or different areas. Referrals often seem to get lost"

"It can take a long time to get an update"

The staff that were spoken to came from a range of backgrounds, with those that had management responsibilities indicating that they felt confident that their staff would be aware of when concerns would need to be raised with social care and the process to complete. One of those consulted with advised that their organisation is in the process of developing a role of 'Safeguarding Champion' whose responsibilities would include monitoring referrals to social care.

A number of staff consulted with commented that they very rarely received feedback after a referral has been made and that they spend a great deal of time chasing this to find out the outcome.

4. Summary of strengths and areas for improvement

Strengths identified	Areas for improvement
• Agencies have processes in place to support staff to make referrals to social care; eg flowcharts • Agencies described processes in place to ensure that history was considered when working with customers; with one agency indicating that the use of chronologies has been the recent subject of a deep dive audit review which has resulted in recommendation and actions to improve and embed practice	• Practitioners described delays in being invited to meetings, or lack of invitations • There was evidence that the outcome of referrals is not widely shared, with referring agencies having to chase for this information to ensure the referral had been received and was being acted upon appropriately • There was evidence that the outcomes of assessments were not always shared with colleagues from relevant agencies • Whilst processes have been put in place there remained evidence of inconsistency in quality of use of history and chronologies

Figure 21: Summary of strengths and areas for improvement

KEY FINDINGS: THE VOICE OF THE CHILD, YOUNG PEOPLE & ADULTS

1. Self-Evaluations

Agencies provided a range of information advising how they try to ensure that children and adults are made aware of their right to be safe from harm and abuse which included the use of websites and social media, promotional literature, focussed campaigns and forums. *(Figure 22)*

When asked about ensuring the voice of the child or adult is captured, there was a mixture of responses and understanding. A number of agencies advised that they were aware of advocacy services and would access these if required, and others stated that they would discuss any concerns with the adult or child. It was evident that statutory agencies had very clear processes for ensuring the voice of the child/adult is captured and recorded and staff were trained to understand the importance and value of this.

Figure 22: Right to be safe method

Agencies were asked to provide examples in respect of how they created opportunities to see the child/adult alone, and therefore free from the influence of others. Whilst a number of agencies didn't complete this section there was a range of methods that are utilised, which included:

> *"It is encouraged that patients are seen alone, particularly where there are safeguarding concerns. Maternity also have a policy where they will see a pregnant woman alone at least twice in their pregnancy."*
>
> *"Seeing the person alone is embedded in all levels of training including how this can be achieved in the clinical setting."*
>
> *""Young people are given the opportunity to text a nurse via the ChatHealth text messaging"*

One agency advised that they had reflected on learning from a local CSPR where it was identified that the child was not given the opportunity to be seen alone.

> *"In light of this, over the last 12 months, training is being, and has been undertaken with our workforce in order to:*
>
> *• ensure that actions take account of children and young people's views*
> *• ensure we recognise behaviour as a means of communication*
> *• ensure we understand and respond to behavioural indicators of abuse*
> *• be able to sensitively balance children's and young people's views with safeguarding their welfare"*

A number of agencies cited the impact of Covid 19 on being able to create the opportunity to see children and adults alone. Some evaluations indicated that it was difficult to be certain that the person was alone when conducting telephone conversations however other evaluations suggested that new ways of working, such as the use of Microsoft Teams, provided the opportunity to be able to offer different types of communication methods so people had greater choice.

Agencies were also asked to provide information about how they ensure that appropriate language is used within all written documentation, with victim blaming language being avoided. Agencies advised that this was embedded in induction processes and training provision, with a number indicating that as a result of the self-evaluations they have reflected on the need to audit the use of language in their recordings and have accessed the 7 minute briefing on the subject.

2.Case File Audits and Lessons from Published Reviews

The case file audits explored how well the voice of the child or adult was captured and recorded and asked auditors to consider whether wishes and feelings were considered and recorded with 84% of audits indicating that this was either 'outstanding' or 'good.' Auditors commented:

"Efforts were clear and consistent in trying to engage with and build trust with the adult. There was clear decision making about how best to do this. Clear evidence of trauma informed practice."

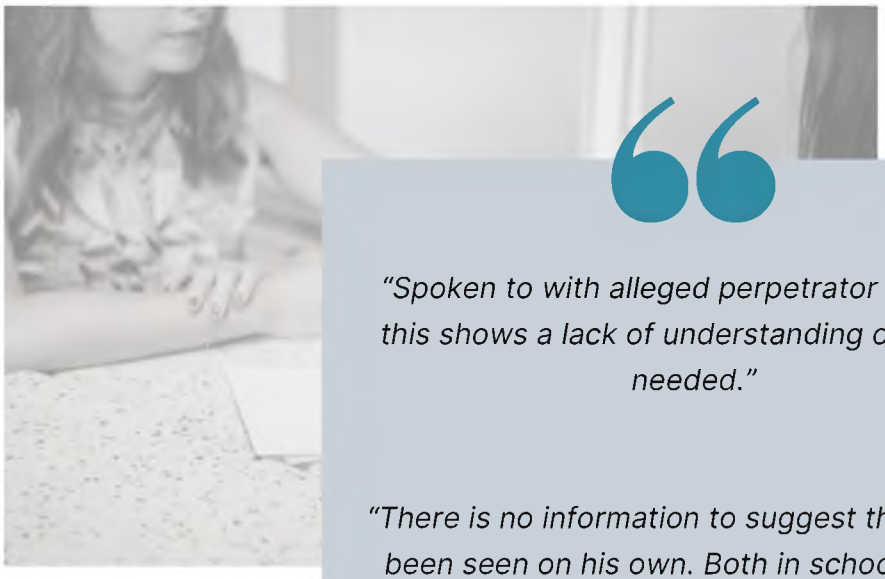
"The safeguarding concerns were discussed with the patient and their wishes and feelings clearly documented."

"The child's voice comes through clearly and they were spoken to on their own and given plenty of opportunity to voice feelings. The child has choice in the treatment and therapy she accessed and the subjects she studied."

"As the child is nonverbal understanding wishes and feelings has been done by learning from behaviour and presentation. It is possible to tell when the child is happy or sad and if they want to engage in an activity or not. Likes and dislikes of the child are well documented in the records."

In respect of ensuring the child or adults voice had been captured throughout the assessment process and informed agreed interventions and outcomes 77% of those that responded indicated that this was of an 'outstanding' or 'good standard' and a further 81% indicated that this was also the case within recordings of case conferences, meetings and reviews.

The audit also asked auditors to indicate whether opportunities were created to see the child or adult alone with 90% indicating practice was either 'good' or 'outstanding.' Whilst evidence of practice that was either 'requires improvement' or 'unsatisfactory' was low there were some comments that are helpful to reflect upon;



"Spoken to with alleged perpetrator present- this shows a lack of understanding of what is needed."

"There is no information to suggest that he has been seen on his own. Both in school and on home visits, he has been observed within the environment with other adults around."

It is also important to note that only 40% of audits commented on whether or not these opportunities had been created with the remainder not commenting on this question.

A number of published reviews have identified common themes that relate to the use of the voice of the child, young person and adult. The full reviews can be read on the WSP website; below is a summary of relevant findings:

EXAMPLE: Creating Opportunities to See the Adult / Child Alone

AMY: Children brought to antenatal clinic must be seen on their own at some point on first appointment

EXAMPLE: Hearing and Recording their Voice

AMY: The Safeguarding Board should seek assurance that effective advocacy is in place to ensure the voice of the child is central to case management of the child.

ALAN: Advocacy (IMHA) was not used effectively in this case and the involvement of an advocate to represent Alan as a qualifying person under the mental Health Act, whilst being cared for under sections 2 and 3 of the Act may have assisted the relationships, joint understanding and provided independent support to Alan. Part of this discussion should have included the suitability of the family acting as advocates.

PRADA & JORDAN: The importance of building and maintaining relationships with children and young people should never be under-estimated.

JAMES: The multi-agency team around the child needs to adopt a flexible approach where the practitioner best placed to develop a relationship with the child and their family takes a lead in ensuring the child's voice is heard

3. The Journey of the Child / Adult

As part of the audit process, 6 cases were reviewed by WSP Business Team to try and understand the child and adults journey through support. The key findings have been summarised below:

Adult 2

This adult had been known to Social Care and Support, 2 hospital trusts and their GP; the GP commented that they were not aware a social care case was open for this adult. The initial referral was in respect to an unsafe discharge, and whilst the response was prompt, inadequate advice was given. The recordings do not indicate that the adults wishes, and feelings were gathered and recorded. The adults voice was not captured as part of this concern, hospital recordings are possibly associated with general well-being whilst the adult was a patient, not directly associated with the safeguarding concern. The response provided to the referrer was inadequate in itself and should have been followed through by the Safeguarding Team. There is room for improvement in the management of feedback on referrals to ensure everyone is aware of the status of their concerns and actions taken. Information sharing was poor at all levels and needs improvement to ensure all relevant agencies are aware of concerns and have a clear understanding of actions to be taken by each.

> *" We have not been made aware that a referral was made and have not been asked to engage in multi-agency decision making with regards to this patient."*

Adult 5

This adult had been known to Social Care and Support, the police, CWPT and a hospital trust. The information provided demonstrates good inter agency working and information sharing regarding the safeguarding of A5 against abuse. Information was gathered and shared in a timely and robust way with professionals exercising professional curiosity. Managerial oversight was sought throughout, and referrals were made and responded to in a prompt and satisfactory way.

The professional network around A5 have built good working relationships due to previous involvement in A5's plans and interventions are reported to have positive outcomes. Professionals appear keen to seek the views and wishes of C5 and build on their strengths and keep them safe from abuse.

> *"Customer spoken to and views and wishes recorded. Was linked to support form people he knows and trusts. NHS colleagues worked to build his confidence and abilities."*

Adult 9

This adult had been known to Social Care and Support, 2 hospital trusts and their GP. Once the referral for support was received this was managed quickly and information was gathered, although their GP indicated that they were not made aware of the outcome of the referral. Assessments were described as being completed sensitively, as it seems this adult was receiving end of life care. Due to the adults health, it was difficult to obtain their views; an advocate was considered; however, it was felt that this was not appropriate. The next of kin were involved in discussions about support. Whilst social care felt they shared information appropriately this was not the view held by health services, who felt they did not receive adequate information about the outcome of the assessment and commented that they felt having a copy of the assessment would have been beneficial.

> *"The nature of the risks were clearly understood and recorded and the decisions to continue with the current situation as it was, was based on her being end of life and the views and wishes of her husband."*

Child 4

This child had been known to Children's Services, 2 hospital trusts, the police and their GP. Evidence of good, timely information sharing, assessments and multi-agency working is present in this case and in particular when information has been shared across borders. Referrals appear to be dealt with in a timely and appropriate way and line management involvement has been sought throughout. The appropriate risk assessments were also undertaken in a prompt manner.

Children's Services readily acknowledge that previous assessment work could have been more robust regarding professional curiosity, however, improvements have been noted since the children have been open to a CIN and disguised compliance by the parents has been identified. As such the social worker undertakes a high challenge, high support role with the parents and information sharing a regular review meeting are taking place in a timely way. In regard to the voice of the child, it is difficult to assess when the child is pre-verbal and there is no information provided regarding interactions with Child 4's sibling.

> *"Information sharing is apparent both between different local authorities (incidents occurred in Northamptonshire and referred to Warwickshire MASH) and also by agencies within Warwickshire. Referrals made to Children's Services/NHS where appropriate. Strategy meeting held."*

Child 12

This child had been known to Children's Services, 2 hospital trusts, the CWPT, the police and their GP. The initial referral was managed appropriately by all agencies and timely decision making is evident with good management oversight, with good and timely feedback provided to the referrers and kept informed on actions. There was good management oversight of escalation and providing support and guidance to the practitioner; whilst the escalation was raised with the agency, it is evident that the practitioner did not make use of the WS Escalation tool for this purpose.

Whilst professional curiosity was not exercised in the case of this young person, a lot of the agency's responses were directly in relation to incidents as and when they arose, this case could have benefitted from professionals taking a step back to reflect on trends and patterns of concern to support earlier intervention. This was potentially a missed opportunity. However, exploring the young person's cognitive ability to understand risk is evidence of good practice by the professional leading this work. Recording keeping is good and supports sound decision making and assessments have been managed appropriately, within a timely timeframe and enabled relevant actions to be progressed. These have included consideration of the impact on the wider family and good family engagement in identifying and discussing risk factors.

The voice of YP has been central within decision making and is documented within records of the lead agencies and information sharing between agencies, the young person and family/carers is evidenced to be of a good standard and has supported decision making. There was also timely interventions and actions of professionals are ensuring the YP is safer as a result of help and support being provided and helping them to better understand the impact of their own risky behaviour.

> *"There is evidence that missing episodes were recorded and return home interviews are held in timescales, there is records of Missing Intervention Meetings , MACE meetings, Complex Strategy Meetings, evidence that information is recorded and shared between carers, police, CSE about associations and relationships that were of concern."*

Child 15

This child had been known to Children's Services, 3 hospital trusts, the police and their GP. The response to the initial referral, which was a report of physical abuse, was appropriate and timely, with the child being seen the same day, however there was a lack of evidence of feedback to a number of agencies that played a key role in the child's life. A DASH assessment was completed, and a safety plan put into place, however this was not checked robustly.

This child seemingly experienced different standards of practice from the agencies she came into contact with, some were professionally curious, whilst other key agencies were not, and opportunities were missed as a result. It is also evident the information was not shared with agencies as some thought specific support was in place when this was not the case; it was also evident that agencies that had contact with the child were not spoken to as part of the assessment and risk planning process.

> *"There was only minimal attempts made to contact and engage the family consisting of two unsuccessful home visits and one voicemail. There was no curiosity evidenced about what that may be about, no exploration of whether the family were abiding by the safety plan that had been put in place or about how these children were seeing their father over this period of time. There is no evidence as to what the bail conditions were and what this did and did not allow for."*

4. Voices from Child Safeguarding Practice Reviews and Safeguarding Adults Reviews

As part of the partnership safeguarding review process the child/adult and their families are spoken to, where possible, to seek their views in respect of their experiences of the services they received. Captured below are some of the voices from these reviews;

"One significant feature of the involvement with my family was that there was a continuous change of case workers, approximately every six months (sometimes more frequently) there were a number of case workers that I never actually met, or only met once."

"Once again, my views were ignored despite the Court of Protection Order being in place."

"I was informed that over lockdowns there were 17 separate strategy meetings, involving 19 agencies. I have no idea who these were, and what were the outcomes of these meetings, in terms of safeguarding. I feel strongly that we were both failed and let down. My beautiful boy deserved so much more."

"School should have picked up on me always falling asleep in class, I was always getting told off. I told my teacher why I was tired. The teacher didn't question this or follow it up as a concern, why, what was the point of me telling?"

" Why was I not asked what outcomes I wanted. Why were my feelings not considered or identified?"

"Dad was dumped when he left hospital; there was no support in place"

"How can I express myself when I don't know the social worker and there's no relationship or trust built up? I have had so many different social workers and they don't seem to know anything about what was happening. I've had so many social workers; they've come and gone and changed over"

"Why did professionals not take the opportunity to speak to me on my own. Why was I not seen alone, away from home, away from him?"

5. Summary of strengths and areas for improvement

Strengths identified	Areas for improvement
• Agencies provided a range of information advising how they try to ensure that children and adults are made aware of their right to be same from harm and abuse which included the use of website and social media, promotional literature, focussed campaigns and forums • Agencies provided examples of how they ensure children and adults are seen alone • Agencies advised that training in Victim Blaming language has been offered	• The increase in homeworking has provided barriers in speaking with children and adults alone • There was evidence that the child/adults voice is not always recorded and captured in case notes • Regular changes in practitioners working with children/adults provided barriers as developing trusted relationships was more difficult • There was evidence that the child's/adults voice was not always listened to, and professional curiosity applied

Figure 23: Summary of strengths and areas for improvement

CONCLUSION AND MESSAGE FROM INDEPENDENT CHAIR & SCRUTINEER

This strategic thematic review has involved an immense amount of work and I am really pleased with the level of evidence gathered. This has enabled Warwickshire Safeguarding to gain significant insight into safeguarding practice across the county. Placing the spotlight on core safeguarding has helped to identify areas of strengths in practice, as well as, highlighting areas of practice which could benefit from further improvement to help the partnership to achieve better outcomes for children, young people and adults in need of safeguarding.

As the Independent Chair & Scrutineer, I will be looking to Warwickshire Safeguarding partners to understand what measures will be put in place to improve practice. Single-agency action plans have been developed by partners returning a self-evaluation as part of their involvement in this strategic thematic review, I would expect these action plans to be expanded to include the generic areas for improvement identified within each key finding of this report. For those agencies who did not submit a single agency self-evaluation, I would expect to see action plans developed which support the implementation of the improvements highlighted within this report.

More importantly, of note are the efforts of Warwickshire Safeguarding to work hard to engage and capture the voice of children, young people and adults surviving abuse or neglect, as well as the views of their family and carers as part of its ongoing safeguarding reviews work. This is presented as powerful evidence throughout this report and it is imperative therefore, that we take serious note and use this feedback to impact real change in practice across the partnership.

I would like to take this opportunity to extend my sincere thanks to you all for your contribution to this strategic thematic review and for the good work exemplified within this report. This strategic thematic review has provided a valuable baseline for the partnership to review its performance, and to use this information to impact the outcomes for children, young people and adults where safeguarding interventions are required to keep them safe from abuse or neglect.

Elaine Coleridge Smith
Independent Chair & Scrutineer, Warwickshire Safeguarding

APPENDIX.1 – SUMMARY OVERVIEW OF KEY STRENGTHS AND AREAS FOR IMPROVEMENT

Strengths Identified	Areas for Improvement
Leadership and Accountability	
• 83% of these leads have received safeguarding training • 74% state the leads have safeguarding responsibilities stated specifically within their job descriptions • Agencies identified a range of methodology in which they promote the details of their safeguarding leads	• Inconsistency in experience and understanding between agencies in respect of the SAR and CSPR processes, with practitioners indicating limited awareness of learning • Lack of awareness of LLB and 7MB's
Policies, Procedures and Protocols	
• The majority of agencies advised that they have a suite of safeguarding policies and procedures • Range of methods used to share safeguarding policies and procedures; newsletters, intranet and handbooks	• Lack of evidence of processes that are in place to ensure staff awareness remains up to date • Limited awareness of the WSP Escalation Protocol • Limited understating, by practitioners, of what the Escalation Protocol is and when it should be activated • Inconsistency in understanding of Spectrum of Support and thresholds • Self-evaluations advised of knowledge of policies and procedures in respect of self-neglect, 'Think Family' and 'Children Moving Across Authority Borders'; however, staff survey and consultations suggested limited understanding and awareness by practitioners

Recruitment and Selection	
• All agencies have processes in place to complete necessary checks before commencement of employment	• Inconsistency with practitioners experience of induction processes
Staff Training and Development	
• Agencies offer a range of safeguarding training to staff • Agencies complete annual appraisals which reflect on staff development	• Training that links to specific learning from reviews has not always been made available • Staff consultations and surveys indicated limited training being offered in areas such as; professional curiosity. Working with aggressive and controlling parents and carers and capturing the voice of the child/adult • Staff indicated that there is a lack of training in respect of making a good referral • Staff indicated that there is a lack of multi-agency training – with training delivery usually being single agency

Complaints, allegations and Whistleblowing	
• A number of agencies indicated they have information in 'child friendly' styles and suitable for adults with care and support needs in respect of making a complaint • A number of agencies indicated that they utilise a range of methodology to ensure the voices of their customers are heard in respect of quality of services • Practitioners indicated a good knowledge of complaints processes	• Practitioners indicted that they rarely are made aware of the outcomes/learning following complaints
Information Sharing, Communication and Confidentiality	
• Agencies have processes in place to support staff to make referrals to social care; eg flowcharts • Agencies described processes in place to ensure that history was considered when working with customers; with one agency indicating that the use of chronologies has been the recent subject of a deep dive audit review which has resulted in recommendation and actions to improve and embed practice.	• Practitioners described delays in being invited to meetings, or lack of invitations • There was evidence that the outcome of referrals is not widely shared, with referring agencies having to chase for this information to ensure the referral had been received and was being acted upon appropriately • There was evidence that the outcomes of assessments were not always shared with colleagues form relevant agencies • Whilst processes have been put in place there remained evidence of inconsistency in quality of use of history and chronologies

The Voice of the Child, Young People and Adults	
• Agencies provided a range of information advising how they try to ensure that children and adults are made aware of their right to be same from harm and abuse which included the use of websites and social media, promotional literature, focussed campaigns and forums • Agencies provided examples of how they ensure children and adults are seen alone • Agencies advised that training in Victim Blaming language has been offered	• The increase in homeworking has provided barriers in speaking with children and adults alone • There was evidence that the child/adults voice is not always recorded and captured in case notes • Regular changes in practitioners working with children/adults provided barriers as developing trusted relationships was more difficult • There was evidence that the child's/adults voice was not always listened to, and professional curiosity applied