Working Together

Gloucestershire's multi-agency arrangements to safeguard children

April 2019

The document sets out the arrangements put in place to enable local partner agencies in Gloucestershire to meet the requirements of Working Together to Safeguard Children.

HM Government: July 2018

Foreword

Working Together 2018 represents a significant milestone in the development of our collective arrangements to safeguard children and young people in Gloucestershire. It places a 'shared and equal duty' on NHS Gloucestershire Clinical Commissioning Group, Gloucestershire Constabulary and Gloucestershire County Council where, in the past, the local authority was the sole accountable body for local arrangements. We embrace those responsibilities and view this as a real opportunity to further embed child safeguarding considerations across our own agencies and the wider local partnership.

The arrangements set out in this document are a transitional step on that journey. They seek to build on the previous work of the Gloucestershire Safeguarding Children Board, which will be replaced by these arrangements when fully implemented in July 2019. The new arrangements allow us to both build on past practice but also to develop our own local approach. Learning from past incidents and embedding that learning within our organisations are matters that can now develop along local lines reflecting Gloucestershire's collective commitment towards a trauma informed and restorative approach to practice, informed by the learning from Adverse Childhood Experiences (ACEs). Our arrangements will continue to develop as confidence increases. We welcome the contribution of our partners and stakeholders and community to what we would hope is an ongoing and rich conversation.

These arrangements will also be subject to ongoing external challenge by an independent scrutineer who will play an active role in ensuring our approach contributes to tangible change for children and families. The independent scrutineer will work within the framework of our own internal and partnership approach to assuring the quality of all we do.

We all share the same aim; namely, that the safety, health, welfare and well being of our children and young people is secured and that we remain open to learning and improving in order to deal with the many challenges and opportunities presented by a rapidly changing world.

Safeguarding though remains 'everybody's business' and we thank you for your continued support, hard work and commitment.

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CONTENTS

Content		Page
1.0	Background	3
2.0	Scope of Arrangements	3
3.0	Context	4
4.0	Key Groups	7
5.0	Safeguarding Support Unit	8
6.0	TransitionTimeline	10
7.0	Annual Reporting, Business Planning, Performance Management and QualityAssurance	11
8.0	Multi-AgencyThresholdArrangements	12
9.0	Links with Schools, Education Providers and Early Years Settings	12
10.0	Child Death, Rapid Review and Serious Incident Notifications (Ofsted and Youth Justice Board).	13
11.0	Escalation of Professional Concerns – Dispute Resolution	14
12.0	The Views of Children and Families	14
13.0	Domestic Homicide Review Protocol	15
14.0	Child Death Overview Panel	15
15.0	The Role of the LADO and the Allegations Management Process	16
16.0	Appendices	17

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Working Together 2018

Operating arrangements for child safeguarding in Gloucestershire

1. Background

1.1. The document sets out the arrangements to enable local partner agencies in Gloucestershire to meet the requirements of Working Together to Safeguard Children (HM Government: July 2018)

1.2. The arrangements outlined in this document have been informed by the views of Gloucestershire Safeguarding Children's Board (GSCB) partners following a series of conversations facilitated by the GSCB Business Manager, taking account of the HM Government publication 'Working Together: Transitional Guidance (July 2018). They have been considered and approved by the Gloucestershire Safeguarding Children Executive (GSCE) which has been meeting in shadow form since December 2018, alongside the GSCB, as part of the transitional process.

1.3. Gloucestershire County Council, working with local partners, recently set out its vision for Gloucestershire in its 'Looking to the Future 2019-22' document. This identifies key priorities for children and young people; including securing their health and wellbeing and ensuring they have access to a good quality school. The arrangements set out in this document will contribute to the achievement of those priorities.

1.4. Following approval by the GSCE these arrangements will be published by 15 April 2019, with full implementation by 15 July 2019, supported by a transition process to ensure a continuity of collective safeguarding arrangements over the implementation period. This will include ensuring that any serious case reviews commenced prior to the implementation of the new arrangements are completed and published or transferred as required by the transitional guidance. The same will apply to any outstanding child death reviews.

2. Scope of arrangements

2.1. Gloucestershire's Safeguarding Partners view Working Together 2018 as an opportunity to realign collective safeguarding arrangements within the context of the Children's Services Improvement journey, the ongoing development of Gloucestershire's wider multi-agency governance framework and local approaches toward the use of restorative practices and taking action on ACEs within our work with children and families.

2.2. The scope of this document encompasses:

- Terms of Reference for the Gloucestershire Safeguarding Children Executive (GSCE)
- Terms of Reference for Gloucestershire Safeguarding Children's Delivery Board (GSCD)
- Terms of reference and membership for Child Safeguarding Sub Groups and Task and Finish Groups

- Key links between child safeguarding arrangements and the wider governance network for Gloucestershire, including the Health and Well Being Board and Safer Gloucestershire
- The role and scope of the Independent Scrutiny Function within the revised arrangements
- The role of the Safeguarding Business Unit in supporting operating arrangements
- Key multi agency review processes including rapid reviews, child death reviews, domestic homicide reviews and serious incident notifications to the Youth Justice Board
- Multi Agency Child Safeguarding Threshold Arrangements
- Dispute resolution and escalation processes
- Business planning, annual reporting and performance management
- Multi agency child safeguarding training and audit processes
- Links with multi agency risk management process as they relate to the safeguarding of children – Missing And Child Exploitation (MACE), Multi Agency Public Protection Arrangements (MAPPA), Multi Agency Safeguarding Hub (MASH) & Integrated Offender Management (IOM)

3. **Context**

3.1. The revised statutory guidance Working Together to Safeguard Children (July 2018) was published in June 2018 and replaces Working Together (2015) as the key statutory guidance for local partner agencies to ensure children are kept safe from harm and that the welfare of all children is promoted. Within the guidance, safeguarding and promoting the welfare of children is defined as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes

3.2 Whilst the revised guidance acknowledges the continuing safeguarding duties of local agencies and organisations, the amendments to the Children Act 2004 introduced by the Children and Social Work Act 2017, establish three safeguarding partners with a 'shared and equal duty' to make arrangements to work together. A safeguarding partner in relation to a local authority area is defined as:

- The local authority
- A clinical commissioning group for an area any part of which falls within the local authority area
- The Chief Officer of Police for an area any part of which falls within the local authority area

3.3 The arrangements set out in these proposals will apply to the County of Gloucestershire, with the safeguarding partners (as defined above) being:

- Gloucestershire County Council
- Gloucestershire Constabulary
- NHS Gloucestershire Clinical Commissioning Group

3.4 The child death review partners for Gloucestershire are:

- Gloucestershire County Council
- NHS Gloucestershire Clinical Commissioning Group

A particular consideration in Gloucestershire is that around 8 -10,000 citizens are registered with NHS Wales and, as such, key services for children and young people such as midwifery, health visiting and GPs will be provided by services outside of Gloucestershire. In the event of a safeguarding concern**,** involving a child or young person within that cohort, NHS Gloucestershire CCG will liaise with the relevant NHS Wales agency on behalf of the Safeguarding Partners. It is acknowledged that this does not affect the accountability for child safeguarding arrangements, which remains with the Gloucestershire Safeguarding Partners.

3.5 The three safeguarding partners, working though the executive, delivery board and sub groups established under these arrangements, will co-ordinate their safeguarding services and engage the wider range of partners with continuing Section 11 duties, including:

- local authority - children's and adult social care services, public health, housing, sport, culture and leisure services, licensing authorities and youth services
- NHS organisations and agencies and the independent sector, including NHS England and clinical commissioning groups, NHS Trusts, NHS Foundation Trusts and General Practitioners
- Police, including police and crime commissioners and the chief officer of each police force in England and the Mayor's Office for Policing and Crime in London
- British Transport Police
- National Probation Service and Community Rehabilitation Companies
- Governors/Directors of Prisons and Young Offender Institutions (YOIs)
- Directors of Secure Training Centres (STCs)
- Principals of Secure Colleges
- Youth Offending Teams/Services (YOTs)

3.6 Within these arrangements, the wider safeguarding partnership comprises:

- Gloucester City Council
- Cheltenham Borough Council
- Stroud District Council
- Tewkesbury Borough Council
- Forest of Dean District Council
- Cotswold District Council
- District Safeguarding Network
- HM Court Services

- Crown Prosecution Service
- National Probation Service
- Bristol, Gloucestershire, Somerset andWiltshire Community Rehabilitation Company
- CAFCASS
- Gloucestershire Care Services
- 2gether NHS Foundation Trust
- General Practitioners Representative
- Gloucestershire Hospitals NHS Foundation Trust
- South West Ambulance Service Trust
- Gloucestershire Association of Special School Heads
- Gloucestershire Association of Primary Heads
- Gloucestershire Association of Secondary Heads
- Further Education Representative
- Gloucestershire Fire & Rescue Service
- Gloucestershire Diocese – Multi Faith Representative
- Barnardos – Voluntary Sector Representative
- Laymember(s)

3.7 The revised guidance includes a new requirement for the independent scrutiny of any local arrangements established under Working Together 2018. The guidance is not prescriptive around the form these should take; however, following initial discussions between safeguarding partners they have agreed to appoint a suitably qualified and experienced individual commissioned to fulfil this function, on an interim basis. The current GSCB Independent Chair stepped down from the role in December 2018. An Independent Chair (experienced ex DCS) commenced in January 2019, on an interim basis, in order to support the transition from the existing arrangements and fulfil the role of Independent Scrutineer until a permanent appointment is made.

3.8 The Safeguarding Partners have agreed to take a pragmatic approach towards the development of local arrangements in building on existing priorities where these are relevant; and, established multi-agency safeguarding arrangements where these are shown to be effective and fit for purpose. These arrangements are captured within the appendices attached to this document and reflect a mix of new developments and the continuation of existing arrangements.

3.9 The interim GSCB Chair, working with local partners, has identified a range of priorities which the Safeguarding Partners have agreed to retain within the new arrangements for 2019/20. The priorities (below) comprise of a range of capacity building measures aimed to enhance collective arrangements alongside specific areas of concern or risk, as evidenced through quality assurance, data and needs assessment. These include:

Capacitybuilding:

- Child Safeguarding Performance Dashboard
- Application of Thresholds
- Impact of training and learning from SCRs etc.
- Vulnerability Profile/Strategy

- Compliance with safeguarding procedures
- Conduct and effectiveness of Strategy Discussions

Keysafeguarding themes:

- Assurance on Early Help – including issues of consent
- Impact of CSE Strategy and Action Plan
- Children who go 'missing'
- Elective Home Education

3.10 During October 2018 Gloucestershire Multi-Agency Safeguarding Hub (MASH) became fully operational through the co-location of key practitioners within Shire Hall, Gloucester. The development of the MASH is subject to collective oversight by a MASH Delivery Group which comprises of senior representatives from local partner agencies and is, in turn, accountable to the GSCE. There is a consensus amongst the Safeguarding Partners that the Gloucestershire MASH is the key interface for operational activity to safeguard children. The GSCE will maintain oversight of the MASH Delivery Group. Gloucestershire MASH is underpinned by a multi-agency threshold document (attached at Appendix 5) to ensure a consistent approach amongst partners towards referrals for children's social care and intervention.

4.1 **Key Groups**

4.2 The essential architecture of Gloucestershire's arrangements to deliver the requirements of Working Together 2018 will comprise:

- A Gloucestershire Safeguarding Children's Executive (GSCE) – comprising of the three Safeguarding Partner Strategic Leads, their respective Lead Officers, an Independent Scrutineer, Safeguarding Business Manager and Chair of the Safeguarding Delivery Board. Terms of Reference for the Executive are attached at Appendix 1.

- A Gloucestershire Safeguarding Children's Delivery Board (GSCD) chaired by a senior officer from one of the safeguarding partners and comprising of local partner agencies set out in paragraph 3.3. The Chair will not be the Safeguarding Partner currently chairing the Executive Group. Mandated by the Executive, the Delivery Board provides the engine room for the development of local child safeguarding and welfare arrangements. Its membership is drawn from senior officers from the three safeguarding partners and wider range of local partners that have continuing duties to collaborate to safeguard and promote the welfare of children. Terms of Reference for the GSCD are attached at Appendix 2.

- Independent Scrutiny of these arrangements is provided by an experienced and qualified individual, commissioned by, but not employed by, the safeguarding partners. The Independent Scrutineer will attend the Quality Assurance and Performance Sub Group working to the Delivery Board and sit as a full member of the GSCE. The Independent Scrutineer would also provide an annual overview report on the effectiveness of local arrangements to the relevant scrutiny and overview

arrangements for each safeguarding partner. This will be developed into a detailed role and person specification as part of an external recruitment exercise for a permanent appointment during 2019. The Independent Scrutineer will be accountable to the Chief Executive of Gloucestershire County Council, the Accountable Officer of Gloucestershire CCG and Chief Constable of Gloucestershire Constabulary, acknowledging the shared and equal duty placed on the safeguarding partners. An outline of the Independent Scrutiny function is attached at Appendix 3 and will underpin these arrangements during the initial operating phase.

- Safeguarding Subgroups are in place to support and inform the working of the GSCE and GSCD as follows:

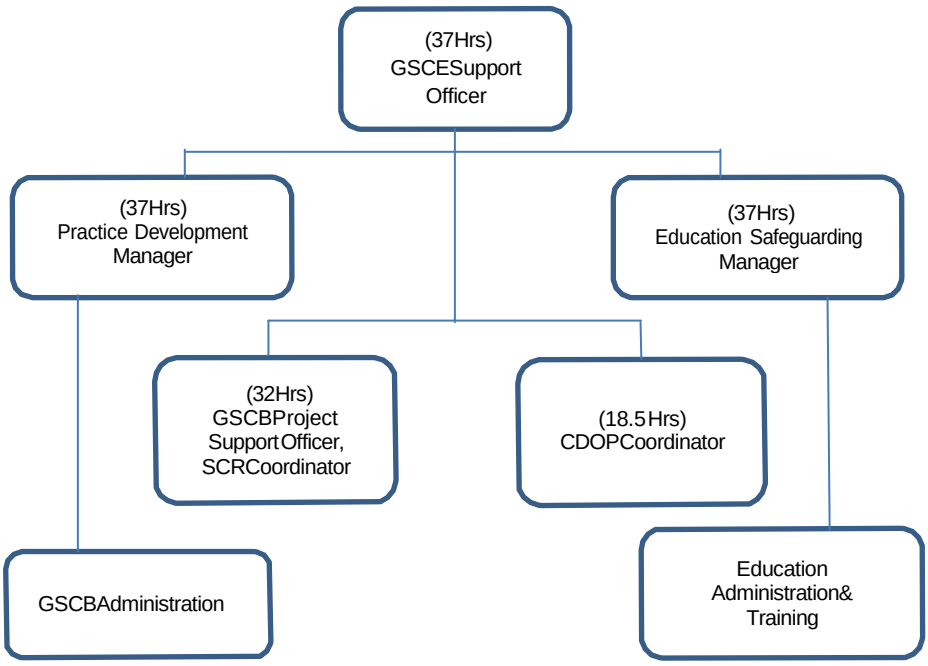
  - Quality Assurance/Intelligence and Performance Group
  - Education Sub-Group
  - SCR/Practice Reviews and Critical Incident Group
  - Policy, Procedures, Training and Learning Group
  - Child Death Overview Panel
  - MASH Operational Group
  - Missing, CSE and Exploitation Sub Group

- On occasion an issue may arise which requires partner agencies to work together through a Task and Finish Group in order to complete a discrete, time banded piece of work on behalf of the GSCE. Previously this has been agreed by the GSCB and will in future be a matter for the GSCE under the arrangements. Acknowledging the significant demands faced by local partners, it is anticipated that the greater majority of child safeguarding activity required by the Executive will be undertaken by the sub-groups and overseen by the GSCD.

4.3 Although the primary focus of these arrangements will be the efficacy and development of local safeguarding arrangements, they will also participate in the development of children's services across Gloucestershire. As such they will have strong links with the Health and Well Being Board and Safer Gloucestershire that focus respectively on the health and wellbeing, and safety, of the whole population. Appendix 4 outlines how the work of the Safeguarding Partners established under Working Together 2018 will integrate within the strategic governance arrangements for Gloucestershire. In order to promote equity and challenge, the Chairs of the Executive and Delivery Board will rotate on an annual basis and will not be held concurrently by the same Safeguarding Partner.

5.1 **Safeguarding Support Unit**

5.2 The child safeguarding arrangements set out in this document are supported by the Safeguarding Support Unit, comprising of:



5.3 The Safeguarding Support Unit, previously the GSCB Business Unit, is responsible for facilitating several fundamental processes which will continue under these arrangements. They include Rapid Reviews, subsequently under the new arrangements local Child Safeguarding Practice Reviews, Child Death Reviews and allegations management (LADO) processes.

5.4 During the transition period following publication of these arrangements, the unit will continue in its current form, with the Business Manager acting as 'lead officer' to the GSCE and GSCD. This would include the team's current role in facilitating the annual programme of multi-agency safeguarding training and multi-agency audit activity attached at Appendix 14. A review of the structure and functions of the Safeguarding Support Unit will be undertaken as the new arrangements 'bed in'.

5.5 Working Together 2018 proposes that the Safeguarding Partners agree a fair and equitable approach to funding any local arrangements. The safeguarding partners have agreed to extend the funding arrangements for (2018/19), as set out in the table below, for the first year of the new arrangements (2019/20) with the local authority as the major funder. The Executive will consider the need for a revised formula to reflect the 'shared and equal duty' placed on 'safeguarding partners' by Working Together 2018 at a future date.

Partner Agency	**%Share**	**£Contribution**
LocalAuthority	69	161,184
Health via the CCG	19.6	45,737
National Probation Service & BGSW CRC	1.0	2,280
OPCC	10	23,720
CAFCASS	0.2	461
Total		**232,382**

6.0 TransitionTimeline

6.1 The DfE timeline for agreeing, publishing and implementing the new safeguarding partnership arrangements is set out in the Working Together transitional arrangements (2018). The guidance also details the arrangements to be followed during the transition from LSCBs to safeguarding partners and child death review partners (including the timeline for managing existing child death reviews) and from Serious Case Reviews to the new national and local arrangements.

6.2 The key transition points (and Gloucestershire's proposals therein) are set out below:

- The 3 Safeguarding Partners have 12 months from the commencement of the provisions of the Act to agree their arrangements – end of June 2019. At its meeting in December 2018, the GSCE agreed the outline operations arrangements within the aim of publication circa 15th April 2019 and full implementation circa 15th July 2019.
- The arrangements when published will be notified to the Secretary of State and NHS England for child death reviews.
- A 12 month period following commencement of the new arrangements, is provided to complete and publish any outstanding Serious Case Reviews, which should aim to be completed within 6 months of an SCR being initiated.
- A four month grace period for CDOPs following commencement of the new arrangements (under the LSCB) to complete child death reviews – no later than November 2019.
- The child death review partners (the local authority and the CCG) have 12 months from the end of June 2018 to agree the arrangements for child death reviews with implementation by September 2019.
- Full implementation of the arrangements, which for Gloucestershire will be July 2019, which will mean that the GSCB no longer exists at that point with the exception of the transitional arrangements for SCR's and CDRs.

6.3 The table below summarises the approach in Gloucestershire:

Keyissue	OutlinePosition
Model for new arrangements	The GSCE, meeting, in shadow form, agreed the basic outline of Gloucestershire's child safeguarding arrangements at its meeting in December 2018. The approach agreed by the 3 Safeguarding Partners has been to build upon existing arrangements in the initial phase in order to ensure a period of continuity, with the opportunity to progressively expand our approach as confidence in our safeguarding arrangements increase.
Support Staffing	It was agreed that the existing Business Unit will continue during the initial implementation phase in lieu of a more extensive review of support resource needs, to be completed during 2019/20

Independent Scrutineer	An outline scope for the Independent Scrutiny Function, delivered on an initial basis by the Interim Chair of GSCB has been agreed by the Safeguarding Partners, pending an external recruitment process to be completed by April 2020.
Timeframe	Publication of these arrangements is scheduled for April 2019 with full implementation by July 2019.

7.0 Annual Reporting, Business Planning, Performance Management and Quality Assurance

7.1 The development of Gloucestershire's safeguarding children arrangements will continue to be informed by a range of comprehensive needs assessments and surveys including:

- Children and Young Peoples' Needs Assessment (2018)
- Safer Gloucestershire Needs Assessment (2018)
- Online Pupil Survey (2018)
- Bright Spots Survey

7.2 A weakness within the previous GSCB arrangements was the absence of a comprehensive data dashboard through which to test the efficacy of collective safeguarding arrangements by reference to relevant performance indicators. At its meeting in March 2019, the GSCE approved a child safeguarding data dashboard drawn from an appropriate range of national indicators, to enable meaningful comparisons to be made with other localities, which will inform these arrangements.

7.3 Reporting on the dashboard will be on a quarterly, retrospective basis and led by the QA and Performance Sub Group with the Independent Scrutineer as a member of that group to provide external challenge and support. The aim will be to provide the GSCD and thereafter the GSCE with a 'narrative' of performance, highlighting areas of effectiveness and of concern, as the basis for collective action, mandated/directed by the Executive. The child safeguarding dashboard will be subject to annual review via the QA and Performance Sub-Group for subsequent approval by the GSCE.

7.4 The GSCB currently uses a variety of approaches to test the effectiveness of safeguarding arrangements across agencies including the use of an annual safeguarding audit – Section 11 Audit (for agencies) and a Section 175 Audit (for schools and colleges). Section 11 responsibilities are reinforced within Working Together to Safeguard Children 2018; however, it also provides the opportunity for the GSCE to explore new models for Section 11 and 175 audits including the potential for shorter thematic audits, conducted on a rolling programme encompassing:

- Safer workforce
- Voice of children and families
- Multi-agencysafeguardingtraining
- Child exploitation and missing
- Thresholds, Policies and Procedures

7.5 In due course the Independent Scrutineer will also explore, within their report, the level and effectiveness of the local response from the local authority and its partners in meeting their collective obligations under Section 10 of the Children Act 2004 to improve the wellbeing of children.

8.0 Multi Agency Threshold Arrangements

8.1 Gloucestershire Safeguarding Partners revised their collective approach toward the provision of support for children and families in January 2018. They set out Gloucestershire's Levels of Intervention Guidance – Working Together to Provide Early Help, Targeted and Specialist Support for Children and Families in Gloucestershire (version 3 – January 2018). A copy is attached at Appendix 5.

8.2 The Safeguarding Partners have agreed to continue this approach within the new arrangements as they have only recently been refreshed, and in light of the recent launch of the co-located MASH in October 2018. It is acknowledged, however, that the levels of contact and referral activity being experienced in Gloucester MASH, alongside the proportion that do not progress, suggest that further work is needed to ensure the consistent application of threshold across partners. A further concern is the inability for the MASH to report on the subsequent development of early help referrals into assessments and 'My Plan' or 'My Plan Plus'.

8.3 A review of the effectiveness of collective threshold arrangements will remain a priority within Gloucestershire's child safeguarding arrangements during 2019/20, with a particular emphasis on workflow through MASH and the impact of early help arrangements.

9.0 Links with Schools, Educational settings and Early Years Providers

9.1 Schools and education providers have robust links with the GSCB through the existing Education Sub Group, which will continue as part of these arrangements. The GCC Director of Education and Schools representatives will also be full members of the GSCD. This is supported by an annual Designated Safeguarding Lead (DSL) Forum for all schools, bespoke training, regular updates and brief guides around thematic issues. The Education Sub-Group also provides a link with the Further Education Sector and private schools, of which there are a number of in Gloucestershire. There will also be the facility for schools to attend the GSCE on an annual basis to feedback on child safeguarding concerns in their sector. They are also parties to an agreed escalation policy.

9.2 The Safeguarding Support Unit will also provide an enhanced safeguarding and training service on a traded basis, which serves around 80% of schools in Gloucestershire. This provides for bespoke training for school staff, advice on the Single Central Record, access to research etc.

9.3 Engagement with early years settings is via an active early years forum with representation drawn from across the sector. This will continue to form part of these arrangements.

10.0 Child Death, Rapid Review and Serious Incident Notifications (Ofsted and Youth Justice Board)

10.1 Ofsted has published guidance on how local authorities should report a serious incident of child abuse or neglect, or the death of a child who is looked after. With effect from 29 June 2018, local authorities in England must notify the national Child Safeguarding Practice Review Panel within 5 working days of becoming aware of a serious incident. Notifications must be made using the online form for notifications of serious incidents for local authorities.

10.2 In order to ensure Gloucestershire Safeguarding Partners and local agencies can comply with these changes, a multi-agency process guide has been developed. A copy of this is attached at Appendix 6. It is important to note that its aim is to ensure a timely and appropriate response by local agencies when they become aware of a child death, acute life threatening event or serious incident.

Once notification has commenced, this will then flow into a Child Death Overview or child safeguarding practice reviews at local or national level, the latter informed by the views of the Child Safeguarding Practice Review Panel.

This will also encompass safeguarding incidents previously notified to the Youth Justice Board under their safeguarding and public protection notification arrangements.

10.3 Responsibility for learning the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel, and at local level with Gloucestershire's Safeguarding Partners. The Multi-Agency Case Review Sub-Group will provide the link between the national and local response to incidents, with the interim Independent Chair taking a final view on the latter, until the full implementation of local arrangements in July 2019.

10.4 The GSCE has overall responsibility for ensuring that all incidents are notified in accordance with local guidance (Appendix 6) to ensure that the reporting requirements are met and whether the criteria for a local review are met. A rapid review will be initiated by the Safeguarding Support Unit, to be completed within 15 days of the notification and sent to the National Child Safeguarding Practice Review Panel.

10.5 Upon full implementation of the new arrangements, the GSCB is replaced with the exception of completing work on SCRs and Child Death Reviews in accordance with the timescales set out in the transitional guidance. This will be delivered in Gloucestershire by retaining the GCSB multi-agency SCR sub-group – which includes the interim Chair (GSCB).

10.6 At the time of writing there are 7 Serious Case Reviews underway. These will be completed and published prior to the final date of 29 September 2020, or will transfer to the GSCE as set out in Working Together 2018 transitional guidance. The Case Review Sub Group and Independent Scrutineer will provide continuity for any Serious Case Reviews which are commenced prior to the publication of Gloucestershire's revised safeguarding arrangement and scheduled to conclude after full implementation in July 2019.

10.8 Any decision to commence a local child safeguarding review (or not to do so) will be for the GSCE, as informed by the findings of the Rapid Review and the advice of the Case Review Sub Group. The Chair of the GSCE shall consult with the Independent Scrutineer on any occasion in which there is a lack of agreement between the SafeguardingPartners.

10.9 Any local child safeguarding practice reviews initiated under these arrangements shall be scoped and commissioned in accordance with paragraphs 30-42 of Working Together 2018. The GSCE, as informed by the work of the Case Review Sub Group, will agree the terms of reference and methodology for any review and appoint the reviewer, having regard to the circumstances of each case and the particular knowledge and expertise this will require of the reviewer. The GSCE will also have the final decision on whether to publish the report (or not) and ensure a copy is provided to the National Panel and DfE no less than 7 working days ahead of publication. The presumption is that the report will be published unless the Safeguarding Partners consider it inappropriate to do so. The rationale for not publishing a local review will also be provided within the same timescales.

10.10 The safeguarding arrangements set out in this document take an incremental approach to change in order to ensure continuity between existing arrangements and the achievement of an initial operating capability that meets the requirements of Working Together 2018 as soon as is practicable. As confidence grows in these arrangements, the consolidation of all reflective and learning activity within a safeguarding learning hub will be a key objective. As a minimum this will provide a focal point and virtual repository for learning material with the aspiration to link with GCC's development of a Social Work Academy as a multi-agency learning venue. It is acknowledged that currently learning activity is spread across a number of existing groups.

11.0 Escalation of Professional Concerns – Dispute Resolution

11.1 The GSCB has recently revised its escalation and dispute resolution guidance in light of the publication of Working Together (July 2018 – page 80). A copy of the escalation guidance is attached at Appendix 7.

11.2 Until full implementation of these arrangements in July 2019, final resolution of any disagreement will be for the interim Independent Chair. Thereafter, the Chair of the GSCE will be the final stage of local resolution, in consultation with the Independent Scrutineer. It is acknowledged that Safeguarding Partners are able to escalate concerns to the Secretary of State if local resolution is not achieved.

12.0 The Views of Children and Families

12.1 Obtaining the views of children, young people and families is essential in ensuring that local agencies and services are well positioned to meet their needs and particularly so in ensuring that the most vulnerable children are effectively safeguarded. The Ofsted inspection (June: 2017) identified that 'the inclusion of young people on the board is generally a strength' and that 'Engagement with the 'Ambassadors' is innovative and influential.'

12.2 The Safeguarding Partners are committed to building on these strengths in developing and implementing the arrangements. A key element within the Independent Scrutiny

function will be to meet, on a regular basis, with the Ambassadors, Children in Care and Care Leavers Groups to ensure their views are contributing towards the development and efficacy of child safeguarding arrangements.

12.3 Over the longer term there is a commitment by the Safeguarding Partners to explore the potential for a 'shadow' child GSCE comprising of young people, supported by the Ambassadors and Children's Engagement Team. The effectiveness of advocacy, return interview and support services for children and young people is a further area for development as part of these arrangements.

13.0 Domestic Homicide Review Protocol

13.1 Safer Gloucestershire, which is the county wide partnership for safer community activity in Gloucestershire, has recently revised its protocol for Domestic Homicide Reviews (DHR) in order to ensure a consistent approach to the completion and dissemination of multi-agency learning across the county. A copy of the revised DHR Protocol (2018) is detailed at Appendix 8.

13.2 There is a recognition within the protocol that a domestic homicide may trigger a requirement for other reviews, such as a child safeguarding practice review. In these circumstances the DHR protocol provides for a joint review process in order to avoid duplication and maximise learning, whilst ensuring the requirements of each review process are satisfied. It is proposed that this will continue through the transition and full implementation period as informed by changes proposed in section 10.0 of these arrangements.

14.0 Child Death Overview Panel

14.1 Gloucestershire has a well established Child Death Overview Panel (CDOP) that facilitates comprehensive multi-agency reviews of child deaths, in order to better understand how and why children die. Gloucestershire works as part of South West CDOP Co-ordination Group and is supported in its arrangements by Bristol University which will continue. Terms of Reference for the Child Death Overview Panel and the outline arrangements for the conduct of a child death review are attached at Appendix 9.

14.2 The child death review partners (led by the CCG and Local Authority) have agreed to continue with the arrangements in the transitional period. As part of the ongoing development of our arrangements, Safeguarding Partners have committed to the purchase of eCR and eCDOP. These will provide a secure, flexible web based solution to facilitate Rapid Review, and CDR processes. This capability will become operational during the first half of 2019/2020.

15.0 The Role of the LADO and the Allegations Management Process

15.1 In order to manage allegations against child care professionals, every Local Authority appoints a Local Authority Designated Officer (LADO). The LADO should be alerted to all cases in which it is alleged that a person who works with children has:

- behaved in a way that has harmed, or may have harmed, a child
- possibly committed a criminal offence against children, or related to a child, or
- behaved towards a child or children in a way that indicates s/he may pose a risk to children. (Working Together 2015)

In this context, the term 'professional' includes paid employees, volunteers, casual/agency staff and self-employed, including taxi drivers and workers who will have contact with children as a part of their role. The LADO ensures that all allegations or concerns about professionals or adults working or volunteering with children are recorded appropriately, monitored and progressed in a timely and confidential way. The LADO is involved from the initial phase of the allegation through to the conclusion of the case. The LADO provides advice and guidance to employers and voluntary organisations, liaising with the Police, Children's Social Care and other agencies, monitoring the progress of cases to ensure that they are dealt with as quickly as possible and are consistent with a thorough and fair process.

In Gloucestershire Allegation Management referrals are complete via a referral form available on the LSCB website and emailed to amadmin@gloucestershire.gov.uk.

General Allegation Management advice is available by contacting the Allegations Management Team on 01452 426320.

16.0 Appendices

Appendix 1 Terms of Reference for Gloucestershire Children's Safeguarding Executive **p17**

Appendix 2 Terms of Reference for Gloucestershire Children's Safeguarding Delivery Board **p18**

Appendix 3 Outline Scope for Independent Scrutiny **p20**

Appendix 4 Links with existing governance and delivery **p21**

Appendix 5 GSCB Threshold document **p22**

Appendix 6 Child Death, Acute Life Threatening Event, Serious Incident and Rapid Review Process **p46**

Appendix 7 Escalation of Professional Concerns guidance **p50**

Appendix 8 Gloucestershire Domestic Homicide (DHR) Protocol **p54**

Appendix 9 Child Death Overview: Terms of Reference **p75**

Appendix 10 Multi-Agency Case Review Sub Group: Terms of Reference **p79**

Appendix 11 Education and Learning Sub Group: Terms of Reference **p81**

Appendix 12 Workforce Development Sub Group: Terms of Reference **p83**

Appendix 13 Multi Agency Quality Assurance Sub-Group: Terms of Reference **p85**

Appendix 14 Multi Agency Learning and Development 2019 – 2020 **p87**

Appendix 15 Allegations Management Flow Chart **p91**

Appendix 1

Terms of Reference Gloucestershire Children's Safeguarding Executive

1. **Purpose**

   To provide effective leadership for the work of local partners and agencies in safeguarding and promoting the welfare of children and young people in Gloucestershire.

   To ensure the effectiveness of local safeguarding arrangements and place the welfare and protection of children and young people at the heart of the local vision for Gloucestershire.

2. **Membership** (Note: Chair will rotate on an annual basis)

- Assistant Chief Constable: Gloucestershire Constabulary (Chair: 2019-2020)
- Head of Public Protection Unit: Gloucestershire Constabulary
- Director of Children's Services
- Director of Children's Safeguarding
- Chief Nurse: Gloucestershire Clinical Commissioning Group
- Designated Nurse Safeguarding Children – Gloucestershire Clinical Commissioning Group
- IndependentScrutineer
- Safeguarding Business Manager (GCSE Support Officer)
- Chair of Safeguarding Delivery Board

3. **KeyObjectives**

   The key objectives for Gloucestershire Children's Safeguarding Executive are to ensure:

- children are safeguarded and their welfare promoted
- there is a robust multi-agency Children's Plan in place to realise the priorities and vision for children and young people set out in 'Looking to the Future 2019-2022' and the 2050 Vision
- there is an exhaustive appreciation of the effectiveness of local safeguarding arrangements through robust quality assurance and performance management arrangements
- there are robust arrangements in place for local child safeguarding reviews and Child Death Reviews
- there is a robust cycle of needs assessment, planning and delivery to support the development of local safeguarding arrangements
- there is early identification and analysis of new and emerging safeguarding issues
- partner organisations and agencies challenge and hold one another to account for the effectiveness of safeguarding arrangements
- learning and continuous professional development are an integral element within local safeguarding arrangements including the learnings from Serious Case Reviews, Critical Incident Reviews and Child Death Reviews
- there are effective information sharing arrangements in place to support accurate and timely decision making for children and families
- the development of local child safeguarding arrangements takes place within the context of the local vision for children and young people in Gloucestershire.

Frequency of meetings: Quarterly

Appendix 2

Terms of Reference Gloucestershire Children's Safeguarding Delivery Board

1. Purpose

To co-ordinate the work of local partners in support of Gloucestershire Safeguarding Children's Executive.

To direct the work of the multi-agency Safeguarding Sub Groups and ensure there are robust links with a wider network of safeguarding activity in locality based partnerships, the education sector and health economy

2. Membership

(Note: Chair will rotate on an annual basis. Members shall be sufficiently senior to be able to take decisions and commit resources)

- Children's Services Director of Partnerships and Strategy (Chair: 2019-2020)
- Safeguarding Business Manager (GCSE Support Officer)
- IndependentScrutineer
- Public Health Representative
- Children's Social Care Director
- Children's Services Director of Education
- Youth Offending Service
- Gloucestershire Constabulary
- Clinical Commissioning Group
- Joint Commissioning Team
- District Councils Representative(s)
- National Probation Service
- Community Rehabilitation Company
- Gloucestershire Association of Secondary Heads - GASH
- Gloucestershire Association of Primary Heads - GAPH
- Gloucestershire Association of Special School Heads - GASSH
- Further Education Representative
- Voluntary Sector Representative(s)
- Young Person Representative (Ambassador)
- Principal SocialWorker
- Faith Sector Representative
- Lay Member(s)
- Gloucestershire NHS Acute Provider
- General Practitioners Representative
- Gloucestershire NHS Community and Mental Health Provider
- CAFCASS
- Gloucestershire Fire and Rescue Service
- GCC Assistant Director Early Help

3. KeyObjectives

Working on behalf of safeguarding partners, the key objectives of the Safeguarding Delivery Board are:

- to ensure the delivery of the vision and priorities established by the Executive as set out in the Children and Young People's Plan.
- that an effective cycle of needs assessment, planning and delivery is in place to support the working of the GSCE.
- local child safeguarding reviews Critical Incident Review and Child Death Reviews are facilitated in a timely manner in accordance with statutory requirements.
- a programme of multi-agency training and development is in place, based on an assessment of local needs.
- the local multi-agency thresholds document is actively promoted and subject to regular review.
- to produce an annual report/assessment of the effectiveness of local safeguarding arrangements, with input/oversight from the Independent Scrutineer.
- to co-ordinate work of the Safeguarding Sub Groups to ensure that their work contributes to strategic aims of the GSCE.
- to facilitate periodic audit of agency Section 11 and Section 175 arrangements or their equivalent.
- to scrutinise the effectiveness of key plans and strategies for children.
- effective performance management and quality assurance arrangements are in place to ensure the GSCE has an exhaustive appreciation of the impact of the local safeguarding arrangements.

4. Frequency of meetings: Six times per year to align with quarterly meeting of the GSCE

Appendix 3

OutlineScope

IndependentScrutinyFunction

1. **Purpose**

   To provide independent, objective scrutiny of the effectiveness of local multi-agency arrangements to safeguard and promote the welfare and well being of all children in a local area.

   This will include arrangements to identify and review serious child safeguarding cases.

2. **Provider**

   This function will be delivered by a suitably qualified and experienced individual commissioned, but not employed by the safeguarding partners. A detailed person specification and job description will be developed to support the function with a transparent and open recruitment process undertaken for the appointment.

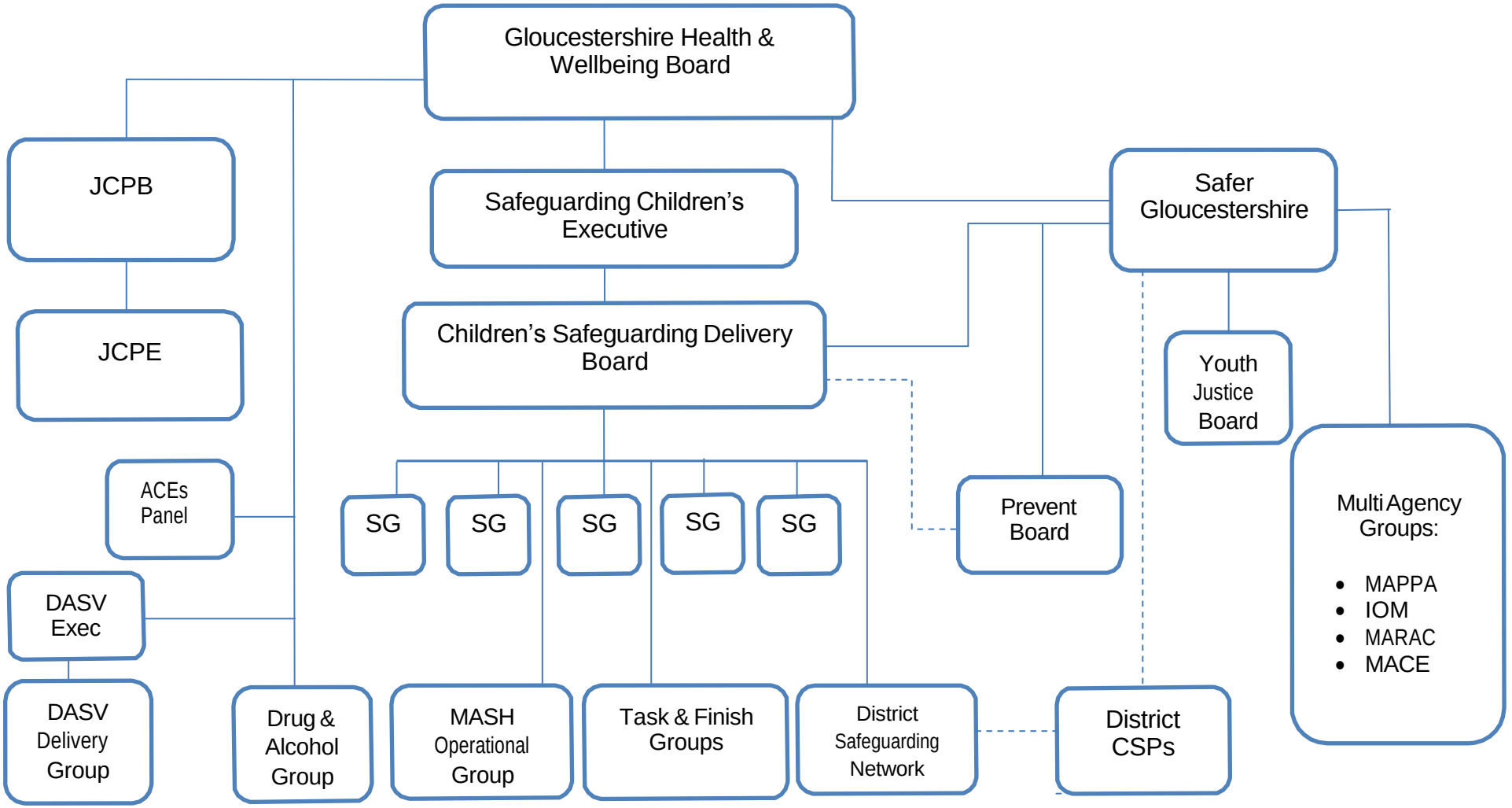
3. **Key Actions**

- to attend the GSCE in an acting as critical friend in testing the efficacy of local arrangements
- to attend the Quality Assurance and Performance sub-group of the Executive
- to provide independent scrutiny and oversight of the annual report on the effectiveness of local arrangements to safeguard and promote the well being of children for consideration by the safeguarding partners, GCSE, GCSD, CSP Review Panel and What Works Centre
- to contribute to the development and implementation of arrangements to identify and review serious child safeguarding cases, including the scoping and commissioning of future reviews.
- to periodically meet the Ambassadors, Children in Care and Care Leavers Groups to ensure the voice of the child is contributing to the development and efficacy of local arrangements.
- to review any relevant reports, assessments, strategies and plans as necessary to provide a transparent and objective view of the effectiveness of local arrangements.
- to contribute to any inspectorate assessments/inspection processes involving local safeguardingproviders.

4. **Review:** Arrangements will be subject to annual review.

5. **Date of Approval:** December 2018

Appendix 4 Working Together links to Gloucestershire Governance Network



Appendix 5

Gloucestershire's Levels of Intervention Guidance.

Working Together to Provide Early Help, Targeted and Specialist Support for Children and Families in Gloucestershire.

1. **Contents**

Contents Page and Revision Table
Introduction
1.0 – What does Effective Support Look Like?
2.0 – Meeting Children and Families' Needs in Gloucestershire
Levels of Need Table
3.0 – Responding to the Needs of Children and Young People in Gloucestershire
Level 1 – Universal Level 2 – Additional Level 3 – Intensive Level 4 - Specialist
4.0 – What happens when Support is requested from Children's Social Care?
5.0 – Escalation of Professional Concerns
6.0 – Allegations Management
7.0 – Key Contacts
8.0 – Some key issues affecting Children and Young People
9.0 – Consent to Sharing Information
10.0 – Key Acronyms
11.0 – Further Guidance

2. **Introduction**

Children and young people deserve to achieve the best possible outcomes and this is at the heart of all our work in Gloucestershire. Most children do very well in the county, but too many experience significant disadvantages which are not always addressed as soon as a problem emerges, and instead are left until they become more serious. Some families and communities may know that there is a problem but won't know where to go to get help and advice. As part of everybody's responsibility for safeguarding children and promoting their welfare, we want to ensure that children and young people at risk are identified at the earliest possible stage and work with them in a coordinated manner to prevent them from reaching crisis point. This is what 'early help' means.

This guidance is for everyone who works with children and young people and their families in Gloucestershire. It is about the way we can all work together, share information and put the child and their family at the centre, providing effective support to help them solve problems and find solutions at an early stage to prevent problems escalating. It aims to make sure the appropriate level of support will be put in place to ensure that a child or young person's needs are met in a robust and timely way. We want all professionals working with children and families to be confident in adopting a culture of 'healthy challenge' and 'doing the right thing' by having open conversations with families and each other and really championing on behalf of the child.

Levels of need act as a guide to professional decision making and are there to ensure that children, young people and families are able to access the right support to improve life chances and keep children and young people safe. They should not be seen as a barrier but a clear continuum based on the needs of the child. Supplementary guidance can be found on the GSCB website www.gscb.org.uk or through the South West Child Protection Procedures

3. **What does Effective Support Look Like?**

There is an increased recognition of the importance of early help when working with children and young people, to reduce the incidences of abuse and neglect and to enable every child to thrive and meet their full potential. Academic research is consistent in underlining the damage to children from delayed intervention and emphasising that professional action to meet the needs of these children as early as possible can be critical to their future. By working together, we are able to develop flexible support services that are responsive to children and families' needs and provide the right level of intervention at the right time. This approach is reliant on local agencies working in partnership to:

- Identify children and families who would benefit from early help
- Undertake an assessment of the need for early help; and
- Provide targeted early help interventions based on the assessed needs of a child and their family in order to significantly improve outcomes for the child.

There are several factors that are essential to being able to deliver effective early support and intervention to children and families.

4. **An open, honest and transparent approach to supporting children and their families**

Asking for help should be seen as a sign of parental responsibility rather than a parenting failure. Support is often more effective when parents feel they are listened to and respected by practitioners. All practitioners need to work honestly and openly with families, having clear conversations about concerns and making sure that they are involved in decision making.

5. **Early, solution focused and evidence based interventions**

We will work with families to help them identify the things that they need to change and the support that they need. For the support to be effective it will be tailored to the family's needs and provided at the lowest level necessary to ensure that the desired outcomes are achieved.

6. **A multi-agency approach to assessment, support and intervention**

Safeguarding and promoting the welfare of children is the responsibility of everyone in Gloucestershire who works or has contact with children and their families. We need to consult each other, share information and work together using our collective skills, knowledge and expertise to deliver the best possible outcomes for the child.

7. **A confident workforce with a common knowledge and understanding about children's needs**

Appropriate, effective and timely support for children and families could not be achieved without the professional judgement and expertise that all practitioners working with children bring to their role. We will support individuals and organisations to develop confident practitioners who can work in an open, transparent and non-judgemental way with families to enable them to make positive choices and changes.

Our work with children and families in Gloucestershire will be based on the restorative practice principles of high expectations, high challenge and high support. To do this, we will:

- Engage with families and work to their strengths
- Focus on preventing problems and building the resilience of parents, children, young people and communities to support each other
- Be clear and consistent about the outcomes we expect
- Be brave enough to stop things that aren't working
- Work together across the whole system, and do what needs to be done, when it needs to be done

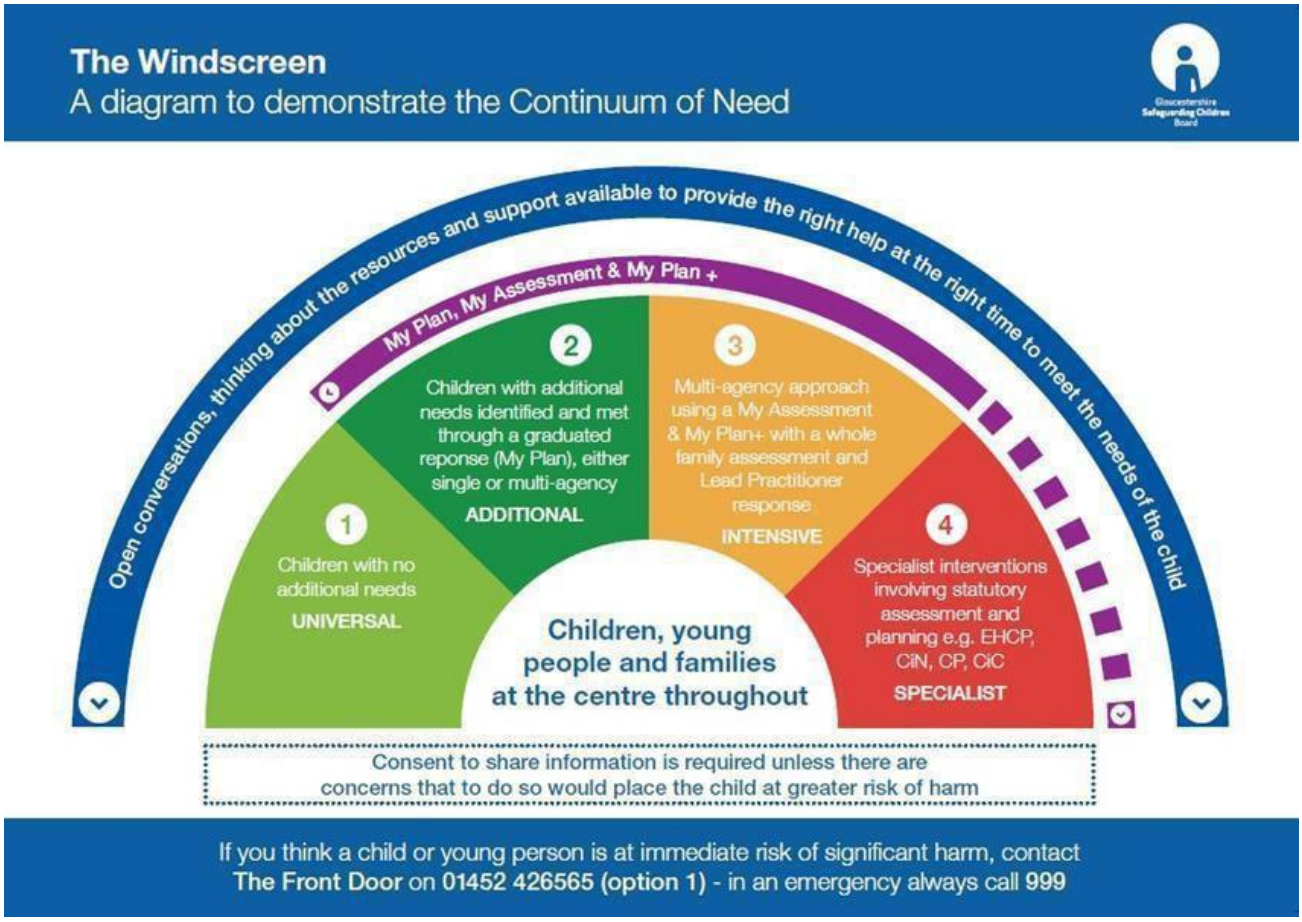
8. **Meeting Children and Families' Needs in Gloucestershire**

Children and families may have different levels of need at different times across a range of issues. Having a graduated approach ensures that support will be appropriate, proportionate and at the lowest level of intervention. In this guidance we have identified four levels of need, Universal, Additional, Intensive and Specialist. Services for children with additional and intensive needs are sometimes known as targeted services, such as additional help with learning in school, behaviour support, and extra support to parents in early years or targeted help to involve young people through youth services. Specialist services are where the needs are so great that statutory and/or specialist intervention is required to keep them safe or to ensure their continued development. Examples of specialist services are Children's Social Care or the Youth Offending Service. This guidance provides a way of working together so that we can use resources more effectively to bring about positive change for children and families in Gloucestershire.

Children might also have a range of needs at different levels. It is important to take all needs into consideration when determining the type of support that might be required and the practitioners who should be involved.

The model used to illustrate the different levels of children and young people's needs in Gloucestershire is referred to as 'The Windscreen' and is a diagram to demonstrate the continuum of need.

9. **The Windscreen – A diagram to demonstrate the Continuum of Need**



All services and interventions seek to work openly with the family (or young person if age appropriate) in order to support them address their needs at the lowest possible level and prevent them from escalating. We will only request services at a higher level after we have done everything possible to meet needs at the current level.

10. **Levels of Need Table**

Level 1 – Universal

Level 1 – Universal Open access to provision	Children and young people are making good overall progress in all areas of their development. They are very likely to be living in a protective environment where their needs are well recognised and met accordingly. These children will require no additional support beyond that which is universally available.	Examples include: ✓ Education Providers ✓ Health Visitors ✓ Midwives ✓ GP's ✓ Universal services accessed through Children and Family Centres, e.g. Stay and Play ✓ Childminders/Nurseries ✓ Leisure centres Advice and guidance to families and professionals is available through **Gloucestershire Family**	Children and young people make good progress in most areas of development

Level 2 – Additional

Level 2 – Additional A coordinated response, through an Early Help Plan – 'My Plan' which may require a single or multi-agency response. The Lead Practitioner will coordinate support and review progress through the Team Around the Child/Team Around the Family where a multi agency response is required.	Children and young people with additional needs, who would benefit from extra help - often from practitioners who are already involved with them. Children and families may need help to: • Improve access to education and educational outcomes • Improve parenting and/or behaviour • Meet specific health or emotional needs • Improve their material situation • Respond to a short-term crisis such as bereavement or parental separation	Examples include: ✓ Early Years Services ✓ Health visitors ✓ Speech and language therapy ✓ Education providers ✓ Educationalpsychology ✓ Group work accessed through Children and Family Centres, e.g. Rainbows Autism Support Group; Young Carers ✓ 2gether CYPS ✓ Youth Support Service ✓ Families First – Early Help Coordinators providing support with the Graduated Pathway ✓ Housing support ✓ Services provided on a voluntary basis	The life chances of children and families are improved by offering early help additional support

Level 3 – Intensive

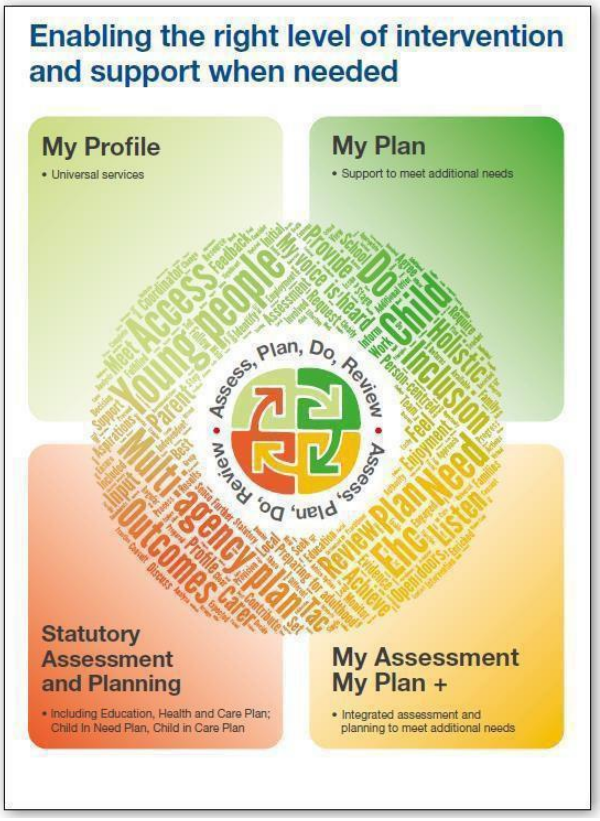
Level 3 – Intensive Targeted early help response taking a multi-agency approach through an Early Help Assessment - 'My Assessment and My Plan+'. The Lead Practitioner will coordinate support and review progress through the Team Around the Child/ Team Around the Family.	Vulnerable children and their families with multiple needs or whose needs are more complex, such as children and families who: • Exhibit anti-social or challenging behaviour • Have poor engagement with key services, such as school and health • Are not in education or work long-term	Examples include: ✓ Specialist health services ✓ Police ✓ Youth Justice ✓ Youth support services ✓ Education providers ✓ Educationalpsychology ✓ Children and Family Centres – Targeted Family Support (for children aged 0-11); Group Work (e.g. Solihull, Webster Stratton, Best Start) ✓ 2gether CYPS ✓ Families First – Targeted Family Support (0- 19); Advice and Guidance through Early Help Coordinators and Community Social Workers ✓ Housing support ✓ Services provided on a voluntary basis	Vulnerable children and families likely to face impairment to their development and life chances will be supported by services to enable them to achieve. Issues will be prevented from escalating into safeguarding concerns requiring statutory intervention

Level 4 – Specialist

Level 4 – Specialist Children in Need of Specialist Support from Children's Social Care, including Children in Need of Protection and Children in Need of Care	A child or young person living in circumstances where there is a significant risk of abuse or neglect, where the young person themselves may pose a risk of serious harm to others or where there are complex needs in relation to disability. • **These children will have complex needs across a range of domains that requires an assessment under the Children Act 1989**	Examples include: ✓ Children's Social Care ✓ Police ✓ Youth Justice ✓ Youth support services ✓ Specialist Education providers ✓ Specialist Health Providers ✓ GDASS	Children and/or family members are likely to suffer significant harm/removal from home/serious and lasting impairment without the intervention of specialist services

11. **Responding to the Needs of Children and Young People in Gloucestershire**

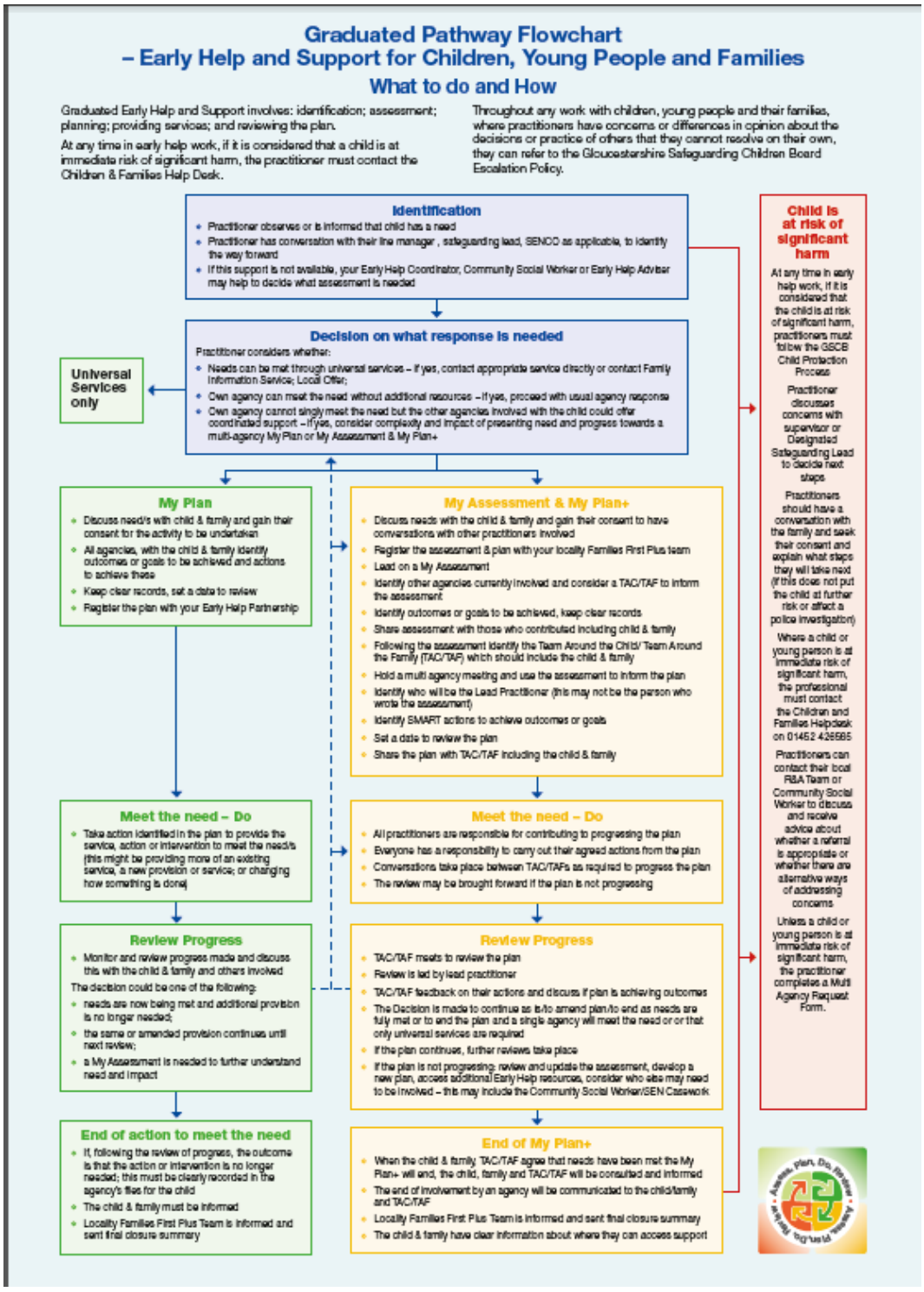
There are some children and families who have additional or multiple needs and need help from one or more professional. The Graduated Pathway is Gloucestershire's response to ensuring Early Help is available to all children, young people and their families with additional needs, whether these are educational, social or emotional needs arising from a disability. It supports children/young people from the very early stages when support is needed and it focusses on what parents and local communities can offer within their own resources.



Children with additional needs may need either specific support from a single agency (e.g. school, health setting and children's centres) or a more coordinated response from a range of agencies. A My Plan is used when it is clear what the presenting needs are and who or what can help. If needs are unclear and the impact is unknown, there is already a significant impact that is likely to escalate or it is unclear what or who may help then a My Assessment and My Plan+ should be considered. Both the My Plan and My Assessment & My Plan+ should be coordinated by an identified Lead Practitioner.

It is inevitable that children will move from one level of need to another over time. The transition should happen seamlessly to ensure that information is shared appropriately between agencies and a Lead Practitioner is identified and clear about their role. Children and families need to be kept informed and should always be part of the decision making.

12. **The Graduated Pathway Flowchart**



13. **Level 1 – Universal –**

These children will require no additional support beyond that which is universally available. The **My Profile** is a universal document that can be used with any child/young person even if they do not have SEND. It is a tool to get to know a child/young person better and understand their preferred style of communication and what is important to them.

Level 1 – Universal: Children and young people are making good overall progress in all areas of their development. They are very likely to be living in a protective environment where their needs are well recognised and met accordingly. These children will require no additional support beyond that which is universally available

Child's Developmental Needs

Health

- Physically well
- Nutritious diet
- Adequate hygiene and dress
- Development and health checks/immunisations up to date
- Development milestones and motor skills appropriate
- Sexual activity age appropriate
- Good mental health

Emotional Development

- Good quality early attachments
- Able to adapt to change
- Able to understand others' feelings

Behavioural Development

- Takes responsibility for behaviour
- Responds appropriately to boundaries and constructive guidance

Identity and Self-Esteem

- Can discriminate between safe and unsafe contacts

Family and Social Relationships

- Stable and affectionate relationships with family
- Is able to make and maintain friendships

Learning

- Access to books and toys
- Enjoys and participates in learning activities
- Has experiences of success and achievement
- Sound links between school and home
- Planning for career and adult life

Parents and Carers

Basic Care, ensuring safety and protection

- Provide for child's physical needs, e.g. food, drink, appropriate clothing, medical and dental care
- Protection from danger or significant harm

Emotional warmth and stability

- Shows warm regard, praise and encouragement
- Ensures stable relationships

Guidance, boundaries and stimulation

- Ensure the child can develop and sense of right and wrong
- Child/young person accesses leisure facilities as appropriate to age and interests

Family and Environmental Factors

Family functioning and well-being

- Good relationships within family, including when parents are separated.

Housing, work and income

- Accommodation has basic amenities and appropriate facilities, and can meet family needs
- Managing budget to meet individual needs

Social and community including education

- They have friendships and are able to access local services and amenities
- Family feels part of the community

Advice and Guidance - Gloucestershire Family Information Service

Gloucestershire Family Information Service provides information, advice and support for families with children aged 0-19 (up to 25 for those with a disability)

14. Level 2 – Additional

These are children and young people who need some additional support, without which they would be at risk of not meeting their full potential. The support that they need may relate to their health, education or social development. If not dealt with as soon as a problem emerges, these issues may develop into more worrying concerns and escalate requiring more intensive support under level 3.

The majority of children and young people with additional needs will require interventions from universal and targeted support through the graduated pathway (such as schools, health visitors, speech and language service, early years settings etc.).

Children, young people and their families have a range of needs. Support is required to promote social inclusion, to reduce vulnerability and/or to minimise risk taking behaviours. If needs are not met then children's health, social development or educational attainment may be significantly impaired. A coordinated response, through a single or multi-agency My Plan is required and the Lead Practitioner will coordinate support.

As a practitioner, you should seek advice from your line manager, the safeguarding lead in your own agency, and Early Help Coordinator or a SENCO as applicable who will be able to advise you on the action that you need to take. If you are clear about the presenting needs, their impact and what or who may be able to help, then complete a My Plan with the child, their family and the agencies involved. This would include the following:

- Discuss needs with child and family and gain their consent for the activity to be undertaken
- All agencies with the child and family identify outcomes or goals to be achieved and actions to achieve these
- Keep clear records, set a date for review
- Register the plan with your Early Help Partnership (through the Families First Team)
- Take action identified in the plan to provide the service, action or intervention to meet the needs (this might be providing more of an existing service, a new provision or service, or changing how something is done
- Monitor and review the progress made and discuss this with the child and family and others involved. The decision could be one of the following:
    - Needs are now being met and additional provision is no longer needed
    - The same or amended provision continues until the next review
    - A My Assessment is needed to further understand need and impact

Remember: Consent to share information from the parent (or young person if appropriate) is required unless there are concerns that to do so would leave a child or young person at risk of significant harm – in which case you should go straight to Level 4.

If you are not sure whether a child's needs can be met through your own agency or whether a more coordinated response is required, then speak with your supervisor, safeguarding lead or your Early Help Coordinator.

Indicators of Possible Need – this is not a full list but is there as a guide to help support decision making. Other factors such as the wider context, age of the child and the resilience of the child and their family should also be taken into consideration

Level 2 – Children and young people whose needs require some additional support, often from the practitioners who are already involved

Child's Developmental Needs

Health

- Slow in reaching developmental milestones
- Weight not increasing as expected
- Missing immunisations or checks
- Susceptible to minor health problems
- Minor concerns ref: diet, hygiene, clothing, alcohol consumption (but not immediately hazardous)
- Disability requiring support services
- Starting to have sex (under 16)

Emotional Development

- Low level mental health or emotional issues
- Substance misuse that is not immediately hazardous, including alcohol

Behavioural Development

- Involved in behaviour seen as anti-social
- Attachment issued and/or emotional development delay e.g. adopted child

Identity and Self-Esteem

- Some insecurities around identity
- Limited self confidence
- May experience bullying around 'difference'

Family and Social Relationships

- Some support from friends and family
- Has some difficulties sustaining relationships
- Low levels of parental conflict

Self-care Skills

- Child is continually slow to develop age-

Parents and Carers

Basic Care, ensuring safety and protection

- Basic care is not provided consistently
- Parent requires advice on parenting issues
- Professionals are beginning to have some concerns around child's physical needs not being met
- Parental engagement with services is poor
- Teenage parent(s)
- Haphazard supervision, unaware of the child's whereabouts
- Some exposure to dangerous situations in the home or community
- Unnecessary or frequent visits to GP or unplanned care settings e.g. ED

Emotional warmth and stability

- Inconsistent parenting but development not significantly impaired
- Post natal depression
- Perceived to be a problem by parent
- Parents struggling to have their own emotional needs met

Guidance, boundaries and stimulation

- Inconsistent boundaries offered
- Child/young person spends considerable time alone (TV etc.)
- Lack of routine in the home
- Child not exposed to new experiences
- Child/young person can behave in an anti-social way

Family and Environmental Factors

Family functioning and well-being

- Parents have relationship difficulties which may affect the child

appropriate self-care skills • Not always adequate self-care - poor hygiene • Disability limits the amount of self-care possible **Learning** • Occasional truanting or non-attendance, poor punctuality • At risk of fixed term exclusion or a previous fixed term exclusion • SEN Support • Few opportunities for play/socialisation • Not in education, employment or training • Identified language and communication difficulties • Not reaching educational potential	• Child may look after younger siblings • Parent has health difficulties **Housing, work and income** • Families affected by low income or unemployment • Parents have limited formal education • Adequate/poor housing **Social and community including education** • Some social exclusion problems • Adequate universal resources but family may have access issues • Family may be new to the area • Victimisation by others

Always make sure that you obtain appropriate consent to share information

Sources of Information and Advice:

- Visit the Information for Practitioners pages on the Glosfamilies Directory website www.glosfamiliesdirectory.org.uk for information and guidance on Gloucestershire's Graduated Pathway of Support for all children with additional needs and early help support that might be available to meet the child's need.
- Contact the CYPS Practitioner Advice Line (01452 894272) or visit www.2gether.nhs.uk/cyps for advice and information
- Information about the Educational Psychology Service can be found at http://www.gloucestershire.gov.uk/education-and-learning/special-educational-needs- and-disability-send/educational-psychology/
- Information about Health Visiting Services can be found at http://www.glos- care.nhs.uk/our-services/nursing/health-visiting
- Speech and Language Therapy Services can be contacted on 0300 421 8937
- Contact the Youth Support Team on 01452 426900 or email info.glos@prospects.co.uk
- Contact your local Early Help Coordinator based in your local Families First team for support around implementing the Graduated Pathway

15. **Level 3 – Intensive**

Children with intensive needs will require targeted support and specific interventions linked to a clear assessment of need. Their needs will be met through the completion of a My Assessment & My Plan+, which is regularly reviewed through a Team Around the Child (TAC) or Team Around the Family (TAF) meeting. A My Assessment & My Plan+ may be required due to complex needs arising from a child's SEN/D and the range of support that is needed in relation to these needs.

The assessment allows the child, their family and a range of different practitioners to contribute information and insight which will build an overall picture of the child's strengths and needs, and to work together as a Team Around the Child/Team Around the Family

(TAC/TAF) to meet the identified needs.

A Lead Practitioner (LP) must be identified, but this is not necessarily the person who wrote the assessment and could come from any of the partner agencies involved in the TAC/TAF. There are many factors to consider in deciding who should take the Lead Practitioner role. Children and families should always be asked who they would like to act in this role for them; who has a positive relationship with the family? Who has most contact with the family?

The LP role can change throughout the lifetime of the plan depending on the presenting needs. **It is** the responsibility of the Lead Practitioner to coordinate support through the TAC/TAF until all the identified needs have been met. It is the responsibility of the agencies working as part of the TAC/TAF to deliver the agreed actions and provide an update to the Lead Practitioner.

The role of the TAC/TAF is to facilitate:

- Putting the child and family first
- A committed and flexible multi-agency team that will change as needs change
- A holistic assessment of the child and family's needs
- An integrated support plan to meet the needs of the child by achieving outcomes agreed by the TAC/TAF
- Regular meetings/reviews of support plans to ensure that the support is effective
- The TAC/TAF should ensure:
- Good information sharing
- Early identification and intervention
- A lead practitioner (LP) to coordinate the work
- Action where needs are not being met

If you think that a child or young person is at risk of significant harm, make sure that you always discuss your concerns with your supervisor or safeguarding specialist within your own organisation. They will be able to advise you on any action you need to take.

If you think a child or young person is at immediate risk of significant harm, contact The Front Door on 01452 426565 (Option 1) or in an emergency phone 999

Remember: Consent to share information from the parents (or young person if appropriate) is required unless there are concerns that doing so would leave a child or young person at risk of significant harm – in which case you should go straight to Level 4.

A My Assessment and My Plan+ may already have been completed (your Early Help Coordinator can tell you this), in which case you would need to contact the Lead Practitioner who has been coordinating the assessment and plan to date. A review of outstanding actions in the plan would need to be completed.

The effective use of multi-agency assessments and improved integrated working should ensure that Children's Social Care are able to focus resources on those children and families with the highest levels of need.

If a My Assessment and My Plan+ have not already been undertaken, then this is the starting point. You should always speak to the safeguarding lead within your

organisation and seek their advice about who would need to be involved. If it remains unclear then you may also wish to speak with a Community Social Worker within the Families First Team to discuss your concerns as they might be able to support you with managing risk within the community. You can also contact the Children's Practitioner Advice Line on 01452 426565 (Option 3).

Indicators of Possible Need – this is not a full list but is there as a guide to help support decision making. Other factors such as the wider context, age of the child and the resilience of the child and their family should also be taken into consideration

Level 3 – Vulnerable children and their families with multiple needs or whose needs are more complex, such as children and families who are living in circumstances where the worries and concerns are frequent, multiple and over an extended period of time:

Child's Developmental Needs

Health

- Emerging mental health issues
- Missed routine and non-routine health appointments
- Child has some chronic/recurring health problems
- Regular substance misuse (think context)
- Conception to child under 16 (think context)
- Self-harming behaviours
- Concerns regarding weight – underweight or overweight

Emotional Development

- Sexualised behaviour
- Physical and emotional development raising concerns
- Difficulty coping with anger, frustration and upset

Behavioural Development

- Offending or regular anti-social behaviour
- Persistent bullying behaviour
- Persistent disruptive/challenging behaviour at school, home or in the community

Identity and Self-Esteem

- Low self-esteem

Parents and Carers

Basic Care, ensuring safety and protection

- Parent is struggling to provide adequate care
- Domestic abuse, coercion or control in the home
- Parental learning disability, parental substance misuse or mental health impacting on parent's ability to meet the needs of the child
- Parents have found it difficult to care for previous child/young person
- Child has limited positive relationships

Emotional warmth and stability

- Child is rarely comforted when upset
- Receives inconsistent care (think context)
- Child is treated differently to their siblings

Guidance, boundaries and stimulation

- Parents refuse/struggle to set effective boundaries
- Child/young person behaves in an anti-social way in the neighbourhood
- Few age appropriate toys in the house

Family and Environmental Factors

Family functioning and well-being

- Evidence of domestic violence

- Gang membership
- Presentation significantly impacts on all relationships
- Subject to discrimination
- Is socially isolated and lacks appropriate role models

Family and Social Relationships

- Peers also involved in challenging behaviour
- Regularly needed to care for another family member
- Previous periods of Local Authority accommodation
- Misses school consistently

Self-care Skills

- Poor self-care for age – hygiene
- Child's hygiene alienates them from peers
- Disability limits the amount of self-care in a significant range of tasks
- Child has to care for self in a way that is not age-appropriate

Learning

- At risk of permanent exclusion or previous permanent exclusion
- Persistent truanting, poor school attendance
- Not achieving key stage benchmarks
- Persistent NEET

- Acrimonious divorce/separation
- Parental involvement in crime
- Family members have physical and mental health difficulties
- Young person displays anger/aggression towards parents

Housing, work and income

- Overcrowding,temporary accommodation, homelessness, unemployment
- Poorly maintained bed/bedding
- Serious debts/poverty impacting on ability to care for the child

Social and community including education

- Family socially excluded with access problems to local facilities and targeted services
- No community tolerance for the family

The Families First Team. The Families First Team is one of a range of teams within the Early Help Partnership. The role of the Families First Team is to:

- and young people with additional needs.
- Support the coordination and development of local partnerships

Provide advice, guidance and support to practitioners working in the community with children If you need to get hold of a Community Social Worker or Early Help Coordinator in your Families First Team you can contact them via the details below.

Families First Teams:
Cheltenham 01452 328160
Cotswolds 01452 328101
Forest of Dean 01452 328048

Gloucester 01452 328076
Stroud 01452 328130
Tewkesbury 01452 328250

16. **Level 4 – Specialist**

If you think a child or young person is at immediate risk of significant harm, contact The Front Door on 01452 426565 (Option 1) or in an emergency phone 999

Children who are living in circumstances where there is a significant risk of abuse or neglect, where the young person themselves may pose a risk of serious harm to others or where there are complex needs in relation to disability may require a more specialist intervention.

Children with complex Special Educational Needs and/or a Disability may have an Education, Health and Care Plan in place. This is a statutory plan that is issued by a multi-agency panel following a statutory assessment process. An Education, Health and Care plan will be considered if outcomes are not being met through non-statutory assessments and plans.

The key factors to take into account in deciding whether or not a child or young person requires a Children's Social Care intervention under the Children Act 1989 are:

- What will happen to a child's health or development without services being provided; and
- The likely effect the services will have on the child's standard of health and development

Within Level 4 there will be children with the following levels of need:

1. **Children in Need of specialist support from Children's Social Care**

- Children with highly complex needs (including children with disabilities or adopted children)
- Children who have a need for multi-agency high level support and are experiencing compromised parenting
- There is a significant risk of family breakdown or being harmed
    - There is a risk that the child will cause serious harm to themselves or others
- There is a likelihood of significant harm but the initial assessment suggests that the risk can be managed outside a Child Protection Plan

2. **Children in Need of Protection**

- Children and young people who are suffering or likely to suffer significant harm

3. **Children in Need of Care**

- Children who in need of care or have been in the care of the Local Authority

Remember: Information sharing with consent from the parent (or young person if appropriate) is required unless there is evidence that doing so would leave a child or young person at risk of significant harm.

At this level of need either a referral to social care or an intensive specialist statutory service is required. This is also the level at which formal and/or immediate protection of the child/ren may be needed.

The Multi-Agency Service Request Form should be completed and emailed to the Front Door Childrenshelpdesk@gloucestershire.gov.uk If there are concerns that a child is at immediate risk of significant harm the Front Door should be contacted on 01452 426565 (Option 1) and the MARF should be completed and submitted within 48 hours as written confirmation of the verbal request.

The Multi-Agency Service Request Form can be downloaded from the GSCB website: http://www.gscb.org.uk/article/113294/Gloucestershire-procedures-and-protocols

Indicators of Possible Need – this is not a full list but is there as a guide to help support decision making. Other factors such as the wider context, age of the child and the resilience of the child and their family should also be taken into consideration

Level 4 – Children in Need of Specialist Support from Children's Social Care, including Children in Need of Protection and Children in Need of Care

Child's Developmental Needs

Health

- Developmental milestones are not being met due to parental care
- Child has significant disability
- Significant concerns for the child's development as measured by weight and height both under 10th centile
- Child is experiencing extremes of weight as identified by a specialist practitioner
- Child has severe/chronic health problems
- Lack of food linked to neglect
- Persistent substance misuse
- Fabricated illness
- Sexual abuse
- More than one pregnancy under the age of 16
- Early teenage pregnancy
- Disclosure of abuse/physical injury by a professional
- High risk of child sexual exploitation

Parents and Carers

Basic Care, ensuring safety and protection

- Parents unable to provide 'good enough' parenting that is adequate and safe
- Parents have seriously neglected/abused the child
- Parents unable to care for previous children
- Parents are involved in crime
- Chronic and serious domestic abuse involving child/young person
- Extremis views or behaviour
- Parents' mental health or substance misuse significantly affect care of child
- Level of supervision is inadequate given the child's age

Emotional warmth and stability

- Parents inconsistent, high critical or apathetic towards child
- Child is rejected or abandoned

- Refusing medical care endangering life/development
- Non-organic failure to thrive
- Dental decay and no access to treatment
- Non-accidental injury
- Unexplained significant injuries

Emotional Development

- Puts self or others in danger
- Severe emotional/behavioural challenges
- Severe attachment problems and/or severe emotional development delay

Behavioural Development

- Regular and persistent offending and re-offending behaviour for serious offences
- Child who abuses others
- Mental health needs resulting in high-risk self harming behaviours

Identity and Self-Esteem

- Experiences persistent discrimination
- Child has no self confidence
- Young person involved and associating with gangs
- Distorted self image impacting on daily functioning

Family and Social Relationships

- Child in Care
- Care leaver
- Subject to physical, emotional, or sexual abuse or neglect
- Family breakdown related to child's behavioural difficulties
- Is main carer for a family member
- Relationships with family experienced as negative
- Family no longer want to care for child

Self-care Skills

- Neglects to use self-care skills due to alternative priorities e.g. substance misuse
- Precociously able to care for self
- Requesting young child is accommodated by local authority
- Parents own emotional experiences impacting on their ability to meet child's needs
- Child is not comforted when distressed
- Child is often scapegoated

Guidance, boundaries and stimulation

- No effective boundaries set by parents
- Child beyond parental control
- Regularly behaves in an anti-social way in the neighbourhood
- Missing from home for long periods of time

Family and Environmental Factors

Family functioning and well-being

- Significant parent discord and persistent domestic violence
- Child/young person in need where there are child protection concerns
- Family home used for drug taking, prostitution, illegal activities
- Parents are in prison and there are no family/friends option
- Young person displays regular physical violence towards parents
- Destructive/unhelpful involvement from extended family

Housing, work and income

- Physical accommodation places child in danger
- Housing dangerous or seriously threatening to health
- No fixed abode or homeless
- Extreme poverty/debt impacting on ability to care for child
- Family seeking asylum or refugees

Social and community including education

- Family chronically socially excluded
- Extreme rural isolation
- Community are hostile to the family
- Restricting and refusing intervention

• Unaccompanied asylum seeker **Learning** • No education provision • No school placement due to parental neglect • Permanently excluded from school • Significant developmental delay due to neglect/poorparenting	from services

17. **What happens when support is requested from Children's Social Care?**

Professionals should seek consent from parents (or those who hold parental responsibility) or the young person, as appropriate, prior to making contact with Children's Social Care. It is helpful if parents or young people are given an explanation that in order to work out the best way to respond, there may be conversations with partner agencies to decide the most appropriate response. Where consent is not evident, unless immediate safeguarding needs are identified, this can lead to a delay in children and families getting the support that they need.

If you think a child is at immediate risk of significant harm then you should contact The Front Door on 01452 426565 (Option 1)

Contacts are made via a Multi-Agency Service Request Form (MARF) http://www.gscb.org.uk/Frequentlyusedforms and we are currently moving towards this being an online form.

All new contacts are reviewed by a social work practitioner upon receipt who will make decisions about immediate responses, including going back to the referrer where information is not clear.

- If child protection concerns are identified that require an immediate social work response, the contact will be created and sent to the appropriate team for urgent action.
- Where it is identified that the needs of the family would be best met through the early help partnership, the contact will be referred to that service and the referrer advised of the action taken
- There will be situations where it is not immediately clear what would be the appropriate response and further enquiries are needed to establish what action, if any, is required to safeguard or support the child and family. In this instance further enquiries will be made at the Front Door, which may include a MASH enquiry.

The Multi Agency Safeguarding Hub in Gloucestershire is made up of a team of professionals from a number of statutory agencies (social care, police, health, education) who will securely share information to ensure that appropriate and robust decisions are made in relation to safeguarding children and incidents of domestic abuse. This decision then triggers an appropriate and proportionate response by local services in the county to ensure safeguarding and early help needs are identified and supported

18. **Escalation of Professional Concerns**

Differences of opinion relating to the level of risk will exist and are an expected part of quality practice. Professionals are expected to discuss these differences in a professional and productive manner. However, in order to be able to resolve difficulties within and between agencies quickly and openly there are a number of key principles that need to be adopted by all professionals:

- Seek to resolve any professional disagreements at the lowest possible level and within the shortest possible timescales
- Encourage others to challenge or question your own practice
- Respond positively to feedback
- The tone of challenge should be one of respectful enquiry, not criticism – 'be curious'
- Challenge should be evidence based and solution focussed
- Be persistent and keep asking questions
- Always keep a written record of actions and decisions taken

If differences are not able to be resolved at a practitioner level then the issue needs to be raised with line managers who will investigate and liaise with the other relevant manager(s).

Always Remember: The safety and welfare of children and young people is the most important consideration in any professional disagreement

19. **AllegationsManagement**

If you receive an allegation or have a concern about the behaviour of a member of staff or volunteer working with children, and that concern could indicate that a member of staff or volunteer has:

- behaved in a way that has harmed a child, or may have harmed a child; or
- possibly committed a criminal offence against or related to a child; or
- behaved towards a child or children in a way that indicated s/he may pose a risk of harm to children

then you must report your concerns to the most senior person in your organisation not implicated in the allegation.

You should always contact the Local Authority Designated Officer (LADO) for advice prior to investigating the allegation. This is because it might meet the criminal threshold and so your investigation could interfere with a Police or Social Care investigation.

The LADO will offer advice on any immediate action required and will assist with employment and safeguarding issues

20. **Child Exploitation**

When assessing a child or young person's vulnerability, exploitation should always be considered. It is our collective, multi-agency responsibility to identify those children and young people who are at risk of exploitation and our joint responsibility to protect them and safeguard them from further risk of harm. It is important that practitioners understand the term 'exploitation' and recognise this as child abuse so that children

are protected and enabled to recognise the risks in all aspects of their lives and relationships. People often think of child sexual exploitation in terms of serious organised crime, but it may also involve informal exchanges of sex for something a child wants or needs, such as accommodation, gifts, cigarettes or attention. Some children are 'groomed' through peers and individuals who may present as 'boyfriends', who then force the child or young person into having sex with friends or associates.

A screening tool has been developed to help professionals record their concerns about a child or young person. The tools help to build a picture for police, Youth Service and Social Care and ensure that the child receives the most appropriate support and intervention.

21. **Some Key Issues affecting Children and young People Neglect**

Neglect is the ongoing failure to meet a child's basic needs and is the most common form of child abuse. It can be particularly difficult for professionals to recognise the signs of neglect because there is unlikely to have been a significant incident or event that highlights the concerns; it is more likely that there will be a series of concerns over a period of time that, taken together, demonstrate that a child is in need or at risk.

The impact of neglect on children and young people is huge. Neglect causes great distress to children, can lead to poor health, poor social and educational outcomes and in some circumstances may affect the development of a child's brain which compromises the child's ability to make positive attachments. Children's emotional well-being is often affected and this could impact on their school attainment and also their ability to successfully parent in the future.

We have recently introduced a child neglect toolkit in Gloucestershire to assist professionals in identifying and assessing children who are at risk of neglect. For more information, please go to the GSCB website: http://www.gscb.org.uk/i-work-with-children-young-people-and- parents/issues-affecting-children-and-young-people/children-living- with-neglect-neglect-toolkit/

The neglect toolkit should be used in conjunction with this document

22. **Preventing Radicalisation and Extremism**

Radicalisation is a process by which an individual or group comes to adopt increasingly extreme political, social, or religious ideals and aspirations that reject or undermine the status quo, contemporary ideas and expressions of freedom of choice. The threats to children & young people take many forms, not only the high profile incidents of those travelling to countries such as Syria and Iraq to fight, but on a much broader perspective also. The internet, in particular social media, is being used as a channel to promote and engage. Often this promotion glorifies violence, attracting and influencing many people including children and in the extreme cases, radicalising them. We know from research that children can be trusting and not necessarily

Appreciate bias that can lead to them being drawn into these groups and adopt these extremist views, and in viewing this shocking and extreme content may become normalised to it.

Prevent' is a term which is used to describe the Prevent strand of the Governments Counter Terrorism Strategy, which aims to tackle radicalisation and extremism. Prevent is

about safeguarding people and communities from the threat of terrorism. At the heart of Prevent is safeguarding children and adults to provide early intervention to protect and divert people away from being drawn into terrorist activity.

23. **Consent to Sharing Information**

Working Together to Safeguard Children (2015) emphasises the importance of early information sharing and that fear about sharing information cannot be allowed to stand in the way of promoting child welfare and protecting child safety. Considering much of what we offer relies on multi-agency working and engaging with families, it is crucial to describe to families the importance of information sharing as the foundation of professional practice and that in order to share information we need to seek consent.

The DfE Information Sharing Guidance (March 2015) states that "Fears about sharing information cannot be allowed to stand in the way of the need to safeguard and promote the welfare of children at risk of abuse or neglect. No practitioner should assume that someone else will pass on information which may be critical to keeping a child safe".

- There will be some circumstances where you should not seek consent from the individual or their family, or inform them that the information will be shared. For example, if doing so would:
- Place a person (the individual, family member, yourself or a third party) at increased risk of significant harm if a child; or
- Prejudice the prevention, detection or prosecution of a serious crime; or
- Lead to an unjustified delay in making enquiries about allegations of significant harm to a child,"

However, there must be a proportionate reason for not seeking consent and the person **making this decision must try to weigh up the important legal duty to seek consent and** balance that against whether any, and if so what type and amount of harm might be caused (or not prevented) by seeking consent. If unsure, then you should speak to the safeguarding lead within your organisation and seek their advice. If it remains unclear then you may also wish to speak with a Community Social Worker to discuss your concerns further.

24. **Key Acronyms**

CP	ChildProtection
CYPS	Children and Young People's Services
EDT	Emergency Duty Team
FIS	Family Information Service
GDASS	Gloucestershire Domestic Abuse Support Service
GSCB	Gloucestershire Safeguarding Children Board
LADO	Local Authority Designated Officer

Appendix 6

Child Death, Acute Life Threatening Event, Serious Incident & Rapid Review Process 2019

1. **Definitions**

- Unexpected Child Death - An unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.
- Neonatal Child Death - Any baby who dies that has not left hospital since birth. Note: Healthcare Safety Investigation Branch, HSIB investigation conducted separately and in parallel for Neonatal Death.
- Expected Child Death – A child with a life limiting condition and not expected to survive more than 24 hours.
- Acute Life Threatening Event (ALTE) – The unexpected collapse of a child where there is no known antecedent condition that might be expected to cause the collapse at that time. The child may, or may not, die immediately or subsequently from the consequences of the precipitating event or collapse.
- Serious Incident - There is a requirement to report incidents where the local authority knows or suspects that a child has been abused or neglected and:
- the child dies (including suspected suicide) or is seriously harmed in the local authority's area
- while normally resident in the local authority's area, the child dies or is seriously harmed outside England
- Note: The responsibility to designate what constitutes a Serious Incident lies with the Local Authority.
- Rapid Review - When a serious incident or a Consideration for Case Review Referral becomes known to the LSCB, the LSCB should undertake a rapid review of the case within 15 days.

  The aim is to:

- gather the facts about the case, as far as they can be readily established at the time
- discuss whether there is any immediate action needed to ensure children's safety
- consider the potential for identifying improvements to safeguard and promote the welfare of children
- decide what steps they should take next, including whether to commission an SCR

1. Serious Incidents notification			
Working Days	**National Requirement**	**Local CSC Action**	**Lead**
1-5 Whilst ensuring there is no delay in response to safeguard the child or siblings the need to notify immediately needs to be considered. Where appropriate notification should not be rushed.	Notify the National Child Safeguarding Panel via online portal within 5 days of being informed of Serious incident	Serious Incident occurs: There is a requirements to report incidents where the local authority **knows or suspects that a child has been <u>abused or neglected</u> and:** • **the child dies (including suspected suicide) or is seriously harmed in the local authority's area** • **while normally resident in the local authority's area, the child dies or is seriously harmed outside England** NOTE: Serious harm includes (but is not limited to) serious **and/or** long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred. Head of Service to organise the collation of information relating to the case; Consider case narrative and any case links, Consider additional sign off from CSC Director. WT18 "Serious Incidents should also be reported to the relevant local safeguarding children board (LSCB) at **the same time as notifying the panel"**	Head of Service Children's Social Care and MASH It is the responsibility of the local authority to decide if an incident is classified as Serious and therefore reportable as an incident. Head Of Service

2. Rapid Review Process			
Working Days	**National Requirement**	**LSCB Action**	**Lead**
1- 2 (From Notification Of SI or Consideration for SCR referral to LSCB)	Working Together 2018 statutory guidance sets out arrangements, as introduced by the Children and Social Work Act 2017, for a learning system.	**LSCB is notified of serious incident by Local Authority or Receives a Consideration for SCR referral.** GSCB SCR Coordinator instigates The Rapid Review process. Send Rapid Review Notification and Paperwork to all members of the SCR Subgroup Core Members (including leads for all agencies – LA, CCG & Police) advising of referral and request a brief summary of involvement with the family (Information required within 72 hours – 3 Days)	SCR Coordinator GSCB Business Unit / GSCB Business Manager
3 - 9	**NOTE:** Prior to publication of the Counties safeguarding arrangements all SCR considerations must follow the 2015 Guidelines.	**Convene Rapid Review** with nominated leads. Discuss serious incident or SCR Referral and decide if the case meets the criteria for 1. National Practice Review 2. Local Practice Review 3. Local Multi Agency Audit or thematic audit of similar cases 4. Local Learning Event All decisions need to be clearly justified in concise terms at the time of the decision - Including identification of any immediate or urgent actions for agencies Email notification to the LSCB Business unit from the National Panel indicating a Serious Incident has been logged and setting out the Panels expected response Date from the LSCB. This email is received within two days of a SI being submitted.	SCR Coordinator GSCB Business Unit to organise meeting and to minute discussion. **Core Membership:** -SCR Panel Chair GSCB Business Manger -SCR Coordinator - Independent Chair who may wish to attend. -Nominated representatives from key agencies – Note Attendees must be aware of the case, their agencies involvement and be senior enough to represent the agency in any decision to proceed with practice reviews.

Day	National Requirement	LSCB Action	Lead
10 – 13		Rapid Review panel decision communicated to Principle Agency Leads & GSCB Chair.	GSCB Business Manger – (In absence Head of Quality)
14 – 15 (Or Sooner)	Notification of decision to National Safeguarding Children Panel	Notification of Rapid Review decision to National Panel by GSCB together with justification of decision (Copied to SCR Chair and Chair)	GSCB Business Manager (In absence Head of Quality)
Next Steps	WT2015 WT2018	Identify Independent Reviewer if appropriate Await National Panel decision	SCR Coordinator GSCB Business Unit / GSCB Business Manager

As soon as the rapid review is complete, the LSCB Business Unit will send a report to the Child Safeguarding Practice Review Panel.

Points to note:

- Consideration for SCR: - Agencies wishing to refer a case for Consideration for Serious Case Review can submit the referral through the MASH who will consider the referral and pass onto the SCR Coordinator, GSCB Business Manager and relevant Head of Service if known to Children Social Care. If the Case for Consideration meets Rapid Review Threshold the Rapid Review process will be instigated at that point under the same timescales.
- Disagreement: - Agencies who disagree with the decision of the Rapid Review Panel can communicate their concerns by formally writing to the SCR Panel Chair and GSCB Independent Chair outlining why they disagree with the Rapid Review Panel; setting out in detail why they either believe the case to meet, or not meet, the SCR threshold. The Independent Chair will discuss with the SCR Chair and respond to the disagreement within 5 working Days.
- In absence of the nominated lead from partner agency – then a nominated deputy will carry out the role
- In absence of the GSCB Chair the LA Lead will oversee the process
- The SCR Chair will have a nominated deputy
- The GSCB Manager will have a nominated Deputy
- The SCR Coordinator will have a nominated Deputy
- It is essential that all partners adhere to these timelines rigorously, prioritising all actions to meet the need for Rapid Reviews
  If in any Doubt contact the GSCB Business Manager

Appendix 7

Escalation of Professional Concerns Guidance – June 2018

Working Together to Safeguard Children – A Guide to Inter Agency Working to Safeguard Children and Promote the Welfare of Children – July 2018

Dispute Resolution

Safeguarding Partners and relevant agencies must act in accordance with the arrangements for their area, and will be expected to work together to resolve any disputes locally. Public bodies that fail to comply with their obligations under law are held to account through a variety of regulatory and inspection activity. In extremis, any non-compliance will be referred to the Secretary of State. ***(Page 80)***

1. **Introduction**

- Effective working together depends on a culture of open and honest relationships between agencies and professional differences are welcomed by professionals who want the best service for children and young people in Gloucestershire. Problem resolution is an integral part of professional co-operation and joint working to safeguard children in Gloucestershire.
- Disagreement based on a passion to improve outcomes for children is healthy professional practice. Resolution of disagreement is an integral part of professional co-operation and joint working to safeguard children. Effective working together is dependent on an open and honest relationship between agencies and professionals.
- In considering escalation, restorative practice principles are essential – these are high support and high challenge. In addition, at all times the focus should always be on improving outcomes for children.
- Occasionally situations arise when workers within one agency feel that the actions or inaction or decisions of another agency do not adequately safeguard a child/young person.
- This interagency policy defines the process for resolving such professional difference and should be read alongside the Gloucestershire safeguarding children procedures and any relevant internal policies on escalating matters of concern.
- Disagreements can arise in a number of areas, but are likely to arise in the following:

    - Levels of need (Gloucestershire levels of intervention document).
    - Roles and responsibilities
    - The need for action
    - The need for inaction
    - Progressing plans and clear communication
    - Provision of services

- Where professionals consider the practice of other professionals is placing a child/children at risk of harm, they must be assertive, act swiftly and ensure that they challenge the relevant professionals is in line with this policy.
- The primary and paramount consideration is the safety of children.
- Resolution should be sought within set timescale to ensure that children are protected.

- As a guide, professionals should attempt to resolve differences through discussion within one working week or a timescale that protects the child from harm (which ever is shortest).
- Disagreements should be resolved at the lowest possible stage in the 4 stages.

- If a child is thought to be at immediate harm, the designated safeguarding lead in your agency should be informed immediately.
- Any worker, who feels that a decision is not safe or is inappropriate, can initially consult their supervisor/manager to clarify their thinking if required. They should be able to evidence the nature and source of the concerns and should keep a record of all discussions
- Individuals may wish to refer to the Escalation Policy for their organisation to clarify the approachrequired.
- Concerns relating to decisions, suspected wrongdoing or dangers at work within an agency, should be raised in line with each agency's policies for dealing with such matters. This includes but is not limited to those setting out the arrangements for whistleblowing.

2. Stages of Resolution

2.1 Stage One: Discuss with the other worker

- People who disagree should work with an open and honest approach to resolve the problem. This discussion must take place as soon as possible and is best face to face or if that is not practical - by telephone.
- The discussion should outline the reasons why the practice is unsafe for children, specifically what they would like to change for the child and how it is having an impact on the children.
- A Practitioner can discuss the concern with their supervisor/manager. The timescale for resolution: within 5 working days or a timescale that protects the child from harm (whichever is less).

2.2 Stage Two: Escalate to Line Manager

- If the problem is not resolved the worker should contact their manager/supervisor/ named professional in their own agency who should have a discussion with their equivalent supervisor/manager in the other agency.
- The discussion between managers/supervisors/named professionals should include the reasons why the practice is unsafe for children, specifically what they would like to change for the child and how it is having an impact on the children.
- The line managers involved could consider whether it would be helpful to convene a professionals meeting to obtain the views of other agencies as relevant. Any professionals meeting will need to adhere to the information sharing guidance set out in the GloucestershireSafeguarding Procedures.
- If a child is subject of a CP plan, notify the CP Chair, or is a Child In Care, notify the Independent Reviewing Officer (IRO)
- This should be pursued with the supervisor/manager/named professional until they are satisfied the problem has been resolved or they understand the reasons why an alternative decision has been reached.
- A practitioner can discuss with their supervisor/manager/named professional. The timescale for resolution: within 5 working days or a timescale that protects the child from harm (whichever is less).

2.3 Stage Three: Escalate to Senior Managers

- If the problem is not resolved at stage two, the supervisor/manager/named professional reports to their respective manager or named/designated safeguarding representative. These two managers must attempt to resolve their professional differences through discussion.
- Again, at this stage, a professionals meeting could be held engaging other agencies considered if deemed appropriate by the involved managers.
- If there remain disagreements, the expectation is that escalation continues through all the appropriate tiers of management in each organisation until the matter is resolved. This should be escalated up to all tiers of management before it is escalated to the chair of GSCB
- At this stage, a written record of the details of the escalation and action taken to date to resolve it should be sent to the GSCB Business Manager Mail@GSCB.org.uk who will record the matter and may forward on to the respective agency members on the Board to ensure they are engaged in seeking resolution before the matter is raised with the GSCB chair.
- The two senior managers should agree a clear plan of action, which includes timescales in the best interests of the child. The timescale for resolution: within 5 working days or a timescale that protects the child from harm (whichever is less)

2.4 Stage Four: Resolution by GSCB Chair

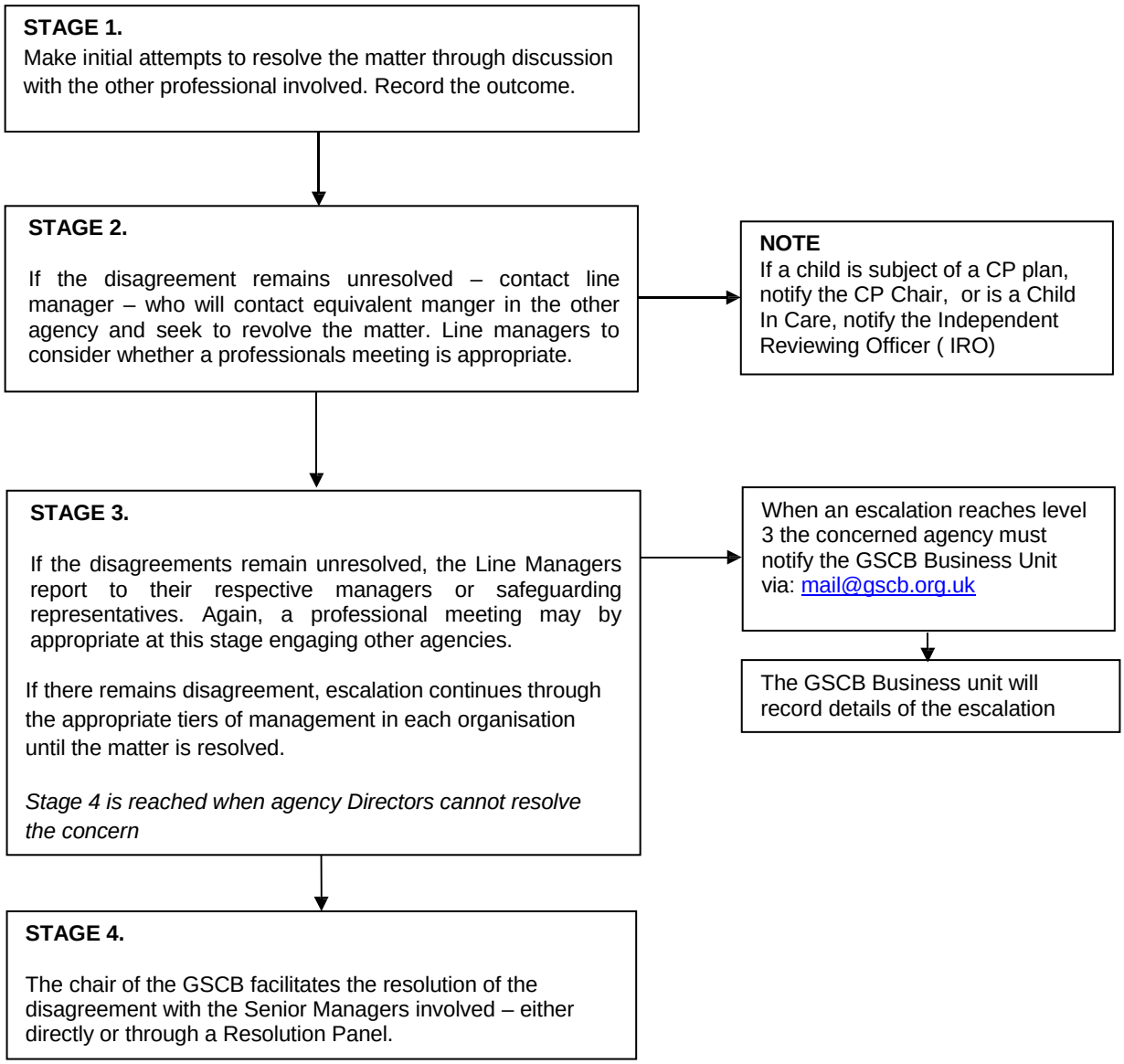
- If professional disagreements remain unresolved, and the professional differences within the agencies concerned (and after the agency's GSCB representative members have been involved), the matter should be referred by the concerned agency to the Chair of GSCB, who may seek to resolve the issue direct with the relevant senior managers, or convene a Resolution Panel.
- The agency raising the dispute must e-mail the details through to mail@GSCB.org.uk
- The Resolution Panel must consist of senior officer from the three agencies who are members of the full Board of the GSCB. The senior officers must include the agencies concerned in the professional differences.
- The Panel will receive representations from those involved in the dispute and will collectively resolve the professional differences concerned.
- The timescale for resolution: within 10 working days or a timescale that protects the child from harm (whichever is less).

  At all stages of the process, actions and decisions must be recorded in writing and shared with relevant personnel (in line with your organisation's information governance and record keeping policies) and to include the worker who raised the initial concern. In particular this must include written confirmation between the parties about an agreed outcome of the disagreement and how any outstanding issues will be pursued.

  It may be useful for individuals to debrief following some disputes in order to promote continuing good working relationships. It is the responsibility of each setting/agency/organisation to record the number of escalations that take place from Stage 1 onwards. These should be reported to the named/designated safeguarding lead within your organisation. This should form part of your organisation's internal quality assuranceprocesses.

3. **Gloucestershire Escalation Flowchart**

You consider that the actions, inaction or decisions of another agency do not adequately safeguard a child.



Appendix 8

Gloucestershire Domestic Homicide Review (DHR) Protocol 2018

1. Introduction

1.1 Background to DHRs

1.2 Definition of a DHR

1.3 Purpose of a DHR

2. Establishing a DHR

2.1 The role of the CSP

2.2 Notification of a death for DHR consideration

2.3 Process following notification

2.4 Overlaps with other review processes

2.5 Appointment of a chair and role of the chair

2.6 Informing the family

2.7 Administration

2.8 Funding

2.9 Media

2.10 Complaints

2.11 Data Protection

3. Conducting a DHR

3.1 Establishing a review panel

3.1a The role of panel members

3.2 Forming the terms of reference

3.3 Review panel meeting structure and timescales

3.4 Chronology and IMR

3.5 Overview report

3.6 Action Plan

4. Process following completion

4.1 Role of CSP following completion

4.2 Quality Assurance

4.3 Publication

4.4 Implementing the action plan

5. Local domestic abuse learning reviews

1. **Introduction**

This document has been produced to:

- Outline how the statutory Domestic Homicide Review (DHR) guidance is applied in Gloucestershire.
- Provide guidance on best practice for establishing a DHR in Gloucestershire.
- Establish governance and accountability for DHRs locally.
- Answer key questions about the DHR process.

This guidance is designed to support community safety partnerships and agencies in establishing and participating in DHRs and should be read in conjunction with the Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.

1. **Backgroundto DHRs**

Domestic Homicide Reviews (DHRs) were established on a statutory basis under the Domestic Violence Crime and Victims Act 2004, with the provision coming into force in April 2011.

The Home Office published its Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews initially in 2011, with its latest refresh in December 2016.

2. **Definition of a DHR**

Domestic Homicide Review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as himself.
- Held with a view to identifying the lessons to be learnt from the death.

Throughout the guidance, where domestic homicide is referred to, it relates to this definition.

Where the definition set out has been met, then a DHR should be undertaken.

'Intimate personal relationship' includes relationships between adults who are or have been intimate partners or family members, regardless of gender or sexual orientation.

The statutory DHR guidance also outlines that where a victim takes their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behavior in the relationship; a DHR should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.

3. **Purpose of a DHR**

The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding

the way in which local professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.
- Prevent domestic violence and homicide and improve service responses for all the domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
- Contribute to a better understanding of the nature of domestic violence and abuse.
- Highlight good practice.

Reviews are expected to not just simply examine the conduct of professionals and agencies, but should 'illuminate the past to make the future safer'; encourage professional curiosity, understanding the trail of abuse and seeing life through the eyes of the victim.

In addition, it is important to note that DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

4. **Establishing a DHR**

The role of the Community Safety Partnership

The Home Office Statutory DHR guidance places responsibility for establishing a DHR with the local Community Safety Partnership (CSP).

The guidance states that where partner agencies operate in more than one local authority area, the responsibility for a DHR rests with the CSP area in which the victim was normally resident. In instances where there is no established address

prior to the incident, lead responsibility will rest with the area in which the victim was last known to have lived.

There may be some circumstances in which lead responsibility for conducting a DHR may not be easily determined. In these complex situations, local areas can make a decision as to how best a DHR can be established.

Within Gloucestershire, each District has its own CSP. A local decision has been made that the County-Wide CSP Safer Gloucestershire will become the statutory body for establishing a DHR for the Districts of Gloucester, Stroud, Cotswolds, Tewksbury and Forest of Dean; with the District CSPs working with Safer Gloucestershire to progress the DHR.

Cheltenham CSP will retain its full statutory responsibility for DHRs, but will have the option of looking to Safer Gloucestershire for support at any stage if they feel this is necessary.

Throughout the rest of this guidance, CSP will refer to either Safer Gloucestershire or

Cheltenham CSP, unless otherwise specified.

The chair of the CSP holds responsibility for establishing whether a death is to be subject of a DHR. In doing so consideration should be given to:

- The DHR definition set out in the statutory guidance.
- Partner agencies views on the death; particularly those who hold specialist knowledge in identifying and understanding the dynamics of domestic abuse.

In instances where the circumstances of the death are complex, it is advised that the CSP forms a small advisory group of key professionals to support decision making.

Appendix 8:3 sets out a summary of the key roles and responsibilities of CSPs in establishing DHRs.

5. **Notification of a death for DHR consideration**

Any professional or agency may refer a death to the CSP in writing for consideration for a DHR, if it is believed that there are important lessons for inter-agency working to be learned. In most circumstances however, the notification will be made by Gloucestershire Constabulary.

All notifications must be made in writing to the relevant District CSP and Safer Gloucestershire as soon as possible following the death. Ideally notifications should be made within a day or two after the death, there will however be some circumstances where notification is made slightly later to ensure details can be confirmed. Notifications must be sent securely via email to the chair of the relevant CSP and the DASV strategic Coordinator.

Appendix 8:4 provides key contact details for CSP members. A template notification letter can be found in Appendix 8:5.

In addition to the formal notification letter, it is recommended that contact should be made via phone with a key lead from the District and/or Safer Gloucestershire.

The notification should include the details of the victim, alleged perpetrator and a summary of the circumstances surrounding the death (as agreed appropriate by the investigation team). The name and contact details of the County Domestic Abuse and Sexual Violence Coordinator should also be included to support the CSP in following the DHR process.

6. **Process following notification**

Once the CSP has received notification, the decision needs to be made as to whether the case meets the criteria for a DHR. In order to support the CSP decision making, it is advised that the CSP call on local expertise, and in particular, work with the County Domestic Abuse and Sexual Violence Strategic Coordinator.

Where the circumstances surrounding a death are particularly complex, and requires greater discussion, it is advised that the CSP work with the DASV Strategic Coordinator to bring together a small panel of local experts to support decision making. This panel should consist of the following agencies:

- CSP lead
- DASV Strategic Coordinator
- Police
- GDASS
- Health
- SocialCare
- Other relevant agency based on circumstances of death

Where an expert panel is required to support the CSP in its decision making, the District CSP will take a lead in arranging.

On receipt of the notification, the CSP should write securely to nominated persons from core partner agencies. This letter should inform them of the following:

- That there has been a death locally that requires consideration for a DHR.
- That they should secure and preserve any records held on individuals involved.
- That they should provide an update on whether they had any involvement with the individuals involved; informing them that they may be requested to attend a decision making meeting to support the CSP in making its decision.

Appendix 8:6 provides a template letter for informing agencies of a potential DHR and inviting them to attend an expert panel to support the CSP.

Appendix 8:7 provides a template letter for informing agencies that a DHR is being conducted and who the independent chair is.

Alongside the DHR statutory definition, the guidance also suggests considering the following when making a decision:

- There was evidence of a risk of serious harm to the victim that was not recognized or identified by the agencies in contact with the victim and/or perpetrator; it was not shared with others; or was not acted upon in accordance with recognised best professional practice.
- Any of the agencies or professionals involved considers that their concerns were not taken sufficiently seriously.
- The victim had little or no known contact with agencies. In these circumstances, the DHR should explore why there was little or no contact.
- The death suggests that there have been failings in one of more aspects of the local operation of formal domestic abuse procedures or other procures for safeguarding adults, including homicides/deaths where it is believed that there was no contact with any agency.
- The victim was being managed by, or should have been referred to, a Multi- Agency Risk Assessment Conference (MARAC) or other multi-agency fora.
- The homicide/death appears to have implications/reputational issues for a range of agencies and professionals.
- The homicide/death suggests that national or local procedure may need to change or are not adequately understood or followed.
- The perpetrator holds a position of trust or authority e.g. police officer, social worker, health professional, and the homicide, therefore is likely to have significant impact on public confidence.

- Services were not available locally to refer/support the victim and/or perpetrator.

Once a decision has been reached by the CSP, they must inform the Home Office (within 1 month of the notification) of their decision via email:DHRENQUIRIES@homeoffice.gsi.gov.uk

7. **Overlaps with other review processes**

There may be some circumstances surrounding the death which could require other multi-agency statutory reviews to be instigated, such as Serious Case Reviews and Safeguarding Adult Reviews. This may include circumstances such as (but not limited to):

- Domestic homicide victim is aged 16-17
- Domestic homicide also involves the death of a child aged under 18
- Domestic homicide victim is a vulnerable adult with care and support needs
- Domestic homicide victim had significant mental health involvement

In these circumstances, the GSCB, GSAB and mental health services, should be consulted to agree a joint review process. This should occur as soon as possible after the notification has been received, and where necessary, involve members of the boards within any expert panel convened to support CSP decision making.

If a joint review is agreed, the relevant boards will need to work alongside the CSP in order to agree the chair appointment, funding and review terms of reference. The CSP and relevant board will also jointly hold the chair and review to account.

The Home Office actively encourages joint reviews to be conducted in these circumstances rather than two separate reviews.

In many cases, criminal proceedings will also be running alongside the DHR process. This should not delay the DHR being instigated and much of the preliminary work, such as agreeing the scope of the review, can be completed prior to criminal proceedings being finalised.

The review chair will link directly with the senior investigating officer (SIO) as early as possible to ensure there are no conflicts of interests between the two processes.

8. **Appointing a chair and role of chair**

The CSP must appoint an independent chair who is responsible for managing and coordinating the review process and for producing the final overview report based on the evidence the review panel decides is relevant. The review chair and report author may be separate people working together or one person who completes both elements of the DHR.
The Home Office Statutory Guidance outlines that the independent chair must:

- Not be directly associated with any agencies involved in the review.
- Not be a member of the CSP.
- Declare their independence within the overview report.
- Have enhanced knowledge of domestic abuse issues including 'honour' based violence, research, guidance and legislation relating to adults and children.

- Have an understanding of the role and context of the main agencies likely to be involved in the review.
- Have managerial expertise.
- Have strategic vision.
- Have good investigative, analytical, interviewing and communication skills.
- Have an understanding of wider statutory review frameworks, such as child/adult reviews.
- Have an understanding of the discipline regimes within participating agencies.
- Have completed the Home Office online training on DHRs, including the additional modules on chairing reviews and producing overview reports.

Locally a list of accredited chairs has been collated, with references from other areas where they have conducted DHRs. This list is held and maintained by the County DASV Strategic Coordinator, with the OPCC also retaining a copy.

Decisions on chairing arrangements will be made by key District Council leads from the CSP alongside the chair/vice chair of Safer Gloucestershire, representative from the OPCC and the DASV Strategic Coordinator. Where the review is a joint process with SCR/SAR process, members of these boards should also be consulted on chairing decisions.

Cheltenham CSP will lead in decision making for chairing of DHRs in their area, but have the option to seek support from Safer Gloucestershire at any time.

Gloucestershire OPCC will issue formal contracts with DHR chairs on behalf of Safer Gloucestershire. Cheltenham CSP will issue its own contract with the DHR chair.

Appendix 8:8 provides a template contract for CSPs to issue to DHR chairs at the point of commissioning them.

9. **Informing the family**

It is the responsibility of the CSP chair to ensure the family, where appropriate, are notified of the decision to conduct a DHR or not. In some circumstances it may not be appropriate for this notification to be made, for example, if it would pose a threat to other familymembers.

The CSP should therefore seek advice from the senior investigating officer, family liaison officer or other agency experts prior to officially informing them of the DHR.

Once the decision to conduct a DHR is made, decisions on when and how to contact the family can be made in conjunction with the independent chair.

The letter to the family should introduce the family to the DHR process and introduce them to the independent chair. Families should be made aware of their option to fully

contribute to the review and be offered the support of specialist advocacy. They should also be asked how they wish future contact to be made with them and how frequently they wish for updates on the review to be given to them.

It is recommended where possible that the Family Liaison Officer (FLO) supports the delivery of the letter to the family and is fully briefed to answer any questions on the DHR process. The FLO is also requested to support the independent chair in making initial

contact with the family to arrange their contribution to the review.

The chair is responsible for meeting family and friends at the earliest opportunity; taking in to account appropriate timing and other processes i.e. post mortems, criminal investigationsetc.

The family will be informed of specialist advocacy as soon as they are informed of the DHR. It is important to note that the chair must not be the advocate for the family as these needs to be provided independently given the report may reach conclusions that the family disagrees with. Once an advocate is in place, the chair should communicate with the family via the advocate where appropriate. Initial contact should be made in person and then agree with the family how they would like future contact to occur and how frequently.

The family should be provided with regular progress updates throughout the DHR and ensure the process and disclosure is explained to them fully. Families should also be informed of how their information has influenced the review.

The Home Office Statutory Guidance, Section 6 outlines the importance of involving the family in the DHR process. This is summarised in Appendix 8:9.

Appendix 8:10 provides a letter template for informing family members of the DHR.

The role of the family is important throughout the DHR and will be referenced throughout Section 3.

The review panel, once established, should consider if appropriate, approaching the family of the perpetrator who may also have relevant information to offer.

10. **Administration**

The District CSP is responsible for identifying an appropriate administrator to support the DHR process throughout. The administrator must be fully aware of the DHR statutory and local guidance and be given enhanced supervision to support them in responding to the DHR.

In some circumstances, the independent chair will provide their own administration for an additional fee.

The role of the administrator is:

- To be the first primary point of contact for queries via phone or email.
- Liaise with clients, statutory and voluntary agencies, to arrange meetings and chase for any outstanding material.
- Prepare and format various documents as required with the use of local templates. For example, Case Chronologies, Individual Management Reviews, formatting of the DHR report.
- Liaise with chair to monitor and update progress against review case.
- Support the chair in making contacts with agencies and where appropriate, the families involved, to set up meetings.
- Prepare meeting agendas in advance of DHR panel meetings.
- Arrange meeting facilities and distribute to attending agencies.
- Act as recording secretary and prepare action minutes for all meetings and interviews.

- Ensure that essential information of a sensitive and/or personal nature is not disclosed to, or discussed with, inappropriate persons and that all information is maintained in accordance with local standards and policies.
- Maintain records and information for the purpose of internal and external monitoring and evaluation of DHR records.
- Support the Community Safety Partnership in the running of the DHR.
- Link with the County DASV Strategic Coordinator in relation to progress with the DHR and queries linked to the process.

11. **Funding**

Costs associated with DHRs are linked primarily with the independent chair, admin and advocacy services for families.

Locally, the OPCC has agreed to fund 50% of the chairing costs up to £5000. The remaining 50% of chairing costs will be shared equally between all of the District CSPs.

Administration costs where possible will be borne locally, but where necessary, costs up to £8000 will be shared by all of the District CSPs.

Where the DHR operates jointly with other review processes, the District CSP should liaise with either the GSAB or GSCB to agree a joint funding model.

Specialist family advocacy will be provided by Advocacy After Fatal Domestic Abuse (AAFDA), a charitable organisation that provides support and advocacy to families to support and guide them through the DHR process and ensure they can influence the process and feed in to the review.

The majority of cases will require a fee from Gloucestershire to AAFDA of £1500. Where DHRs are more complex and greater level of time and resource is required to support the family, costs may increase and reach a maximum of £2500. Any increased costs will be agreed with AAFDA on a needs basis. Costs for specialist advocacy will also be shared equally between the OPCC and District CSPs. A financial agreement for spot purchasing advocacy support has been developed between AAFDA and the OPCC on behalf of the CSPs.

12. **Media**

In some cases it is likely that a domestic homicide will generate media attention. In these instances the communications/press team from OPCC should be the main contact for media enquiries for those districts signed up to Safer Gloucestershire leading on the DHR. Cheltenham Borough Council will be the main point of contact for media enquiries for DHRs running in the Cheltenham District.

It is recommended that the terms of reference for the DHR include a holding statement for the media and agreements on any specific media contact. Whilst the DHR is being conducted, it is recommended that media enquiries are responded to with a general statement confirming that the DHR is in progress and will be published in due course following quality assurance by the Home Office.

Each agency involved in the DHR should also ensure their agency communications

teams are aware of the DHR, the agreed holding statement and communications lead for either the OPCC or Cheltenham Borough Council (CBC).

Prior to publication of the DHR, the communications/press lead from the OPCC or CBC should coordinate a meeting with DHR panel members and their media leads to set out the media approach upon publication. The response to the media will be dependent on the level of interest the case has generated and any likely fallout following agency recommendations.

It is recommended that prior to publication, the communications lead (OPCC/CBC) issue an agreed press release on the findings being published, and that each individual agency is also given the opportunity to issue statements. In high profile cases with a lot of media interest, senior members of organisations should be prepared to speak to the media if required regarding the findings for their agency.

The OPCC press team on issue of the press release will offer the PCC for media interviews as an independent party who can be critical of agencies where necessary and hold agencies to account based on the findings.

Any media response should also highlight agency best practice that has been identified in the DHR.

Whilst CBC will lead on communications for DHRs in their district, they can look towards Safer Gloucestershire for support where required; particularly if the DHR is high profile.

13. Complaints

13.1 Complaints against individual agencies

Where a complaint is made against an individual agency or an agencies member of staff in connection to the DHR, or as a result of their time on the DHR panel, the individual agency should respond via their own complaints procedures.

This should have no impact on the progress of the DHR, but may in some circumstances result in a change of representative on the DHR panel should that agency feel that is necessary.

13.2 Complaints against the Independent Chair

Any complaint against the DHR independent chair should be made in writing to the commissioning body for that DHR; OPCC on behalf of Safer Gloucestershire or Cheltenham Borough Council. The commissioning organisation will respond to the complaint directly with the independent chair and resolve as necessary following their complaints procedure. Where the chair has been commissioned from a wider organisation, complaints will be dealt with through liaison with the organisation rather than the chair directly.

In the unlikely event that the complaint cannot be resolved, or the independent chair is no longer able to fulfil the requirements set out in their contract, the commissioning agency can terminate the contract and commission a new independent chair to continue with the DHR.

13.3 **Complaints against the DHR process or decision to conduct a DHR** In the event that a complaint is made about the decision to conduct a DHR, XX should lead on the initial response.

It is recommended that complaints of this nature are followed up initially through stating the Home Office Statutory Guidance outlining the statutory duty placed on the CSP to conduct such a review by the Government.

Should the complaint continue, the complaints process of XX should be followed, with advice sought from the Home Office as to how to proceed. In some circumstances, permission may need to be sought from the Home Office to not publish such a review should it cause distress to the family or complainant.

Should a complaint be made about how the DHR process is being run, complaints should in the first instance be made to XX. It is then recommended that XX establish with the complainant if the complaint links to the conduct of an agency or the independent chair and follow the processes outlined above as necessary. Should the complaint be more general about the DHR process, it is recommended that XX liaise with the complainant, DHR panel and independent chair to resolve.

14. Data Protection

Section 10 of the Home Office Multi-Agency Guidance for the Conduct of DHRs 2016 outlines the data protection principles for the DHR to consider.

Should any data protection issues arise throughout the DHR, it is recommended that the Home Office be contacted for initial advice, or local data protection officers be consulted.

As with other multi-agency processes, it the individual participating agencies responsibility to ensure they operate under data protection principles.

The independent chair and panel members should consider and include in the terms of reference for the review, the necessary details on data protection as outlined in the Home Office statutory guidance.

15. Conducting a DHR

15.1 Establishing a review panel

Once the criteria for a DHR have been met and a chair has been commissioned, the CSP, alongside the chair, is then required to utilise local contacts to establish a DHR review panel.

Locally, review panels will be constructed on a bespoke basis, dependent on the case and those agencies involved. As detailed under section 2.3, a range of agencies should be written to at the initial stages of scoping a DHR to identify those agencies that hold records on the case in question.

Review panels must however always include some or all of the organisations listed under Section 9 of the Domestic Violence Crime and Victims Act 2004 (local level applied):

- Gloucestershire Constabulary
- Gloucestershire County Council (inc. children and adult social

care/safeguarding)

- Gloucestershire Clinical Commissioning Group
- 2gether NHS Foundation Trust
- Gloucestershire Care Services NHS Trust
- Gloucestershire Hospitals NHS Foundation Trust
- National Probation Service

DHR review panels must also ensure representatives from specialist domestic abuse organisations, locally, Gloucestershire Domestic Abuse Support Service (GDASS).

The DHR review panel must include representation from all agencies involved in the case, as well as any necessary expert organisations to provide guidance and oversight for particular case circumstance or relationship dynamics.

DHR review panels will not have representation from local political members, including local authority councillors so as not to influence the independence of the review. Where political members have dual roles, perhaps as a political member as well as staff within a core agency, they must represent their organisation not their political party. In these circumstances, it is advised that the CSP and chair agree the appropriateness of such panel members and ensure the independence of the review is not impacted.

16. **The role of the panel members**

When agencies and organisations in the county are requested to identify a staff member to be a DHR review panel member, they must consider the following requirements:

- Panel members must be independent of any line management of staff involved in the case.
- Panel members must be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during the panel meeting.
- Panel members must be aware of and bear in mind at all times equality and diversity issues and comply with the requirements of the Public Sector Equality Act duties.
- Panel members must be responsible for working with the IMR author (where different, see3.4) to ensure lessons learned are disseminated appropriately throughout organisations.
- Panel members need to be mindful of their role in working with the independent chair whilst also holding them to account. The DHR overview report is a collective piece of work and all panel members must be satisfied that it accurately represents the discussions held and actions agreed.
- Panel members should appropriately and professionally challenge one another to ensure the identification of lessons to be learnt and the development of SMART action plans.

  Panel members will also be expected to support the development of the terms of reference and agree these prior to the start of the review. Panel members will also be asked to consider if additional expertise is required to support the review process.

Given the enhanced role of the family within the statutory DHR guidelines, panel members should be prepared to meet with the family and answer their questions if the family wishes to do so. This will usually be arranged for one of the final panel meetings, after the family has been given time to read the overview report.

17. **Forming the review terms of reference**

It is the role of the review panel, led by the independent chair, to agree the terms of reference and scope of the review. The scope of the review should ne proportionate to the nature of the homicide.

This activity should be a priority for the first panel meeting.

The statutory DHR guidance provides a non-exhaustive list of considerations when developing the scope of the review:

- What appear to be the most important issues to address in identifying the learning from this specific homicide? How can the relevant information best be obtained and analysed?
- Which agencies and professionals should be asked to submit reports or otherwise contribute to the review including, where appropriate, agencies that have not come into contact with the victim or perpetrators but might have been expected to do so?
- How will the DHR process dovetail with other investigations that are running in parallel, such as an NHS, criminal investigation or inquest?
- Should an expert be consulted to help understand crucial aspects of the homicide? For example, a representative from a specialist BME, LGBT or disability organisations.
- Over what time period should events in the victims and perpetrators life be reviewed, taking into account the circumstances of the homicide i.e. how far back should enquiries cover and what is the cut-off point? What history/background information will help to better understand the events leading to the death?
- Are there any specific considerations around equality and diversity issues that may requirespecial consideration?
- Did the victims or perpetrators immigration status have an impact on how agencies responded to their needs?
- Was the victim subject to a multi-agency risk assessment conference (MARAC) or other multi-agency fora?
- Was the perpetrator subject to multi-agency public protection arrangements (MAPPA)?
- Was the perpetrator subject to a DA perpetrator programme?
- Was the perpetrator subject of a domestic violence protection notice or order (DVPN/DVPO)? Did the victim seek information about the history of the perpetrators criminal history under the Domestic Violence Disclosure Scheme? Did the police make a disclosure under 'right to ask' or 'right to know'?
- Did the victim have any contact with a DA organisations, charity of helpline?
- If relevant, how will issues of so-called 'honour'-based violence be covered and what processes will be out in place to ensure confidentiality?
- How should family members, friends and other support networks, and where appropriate, the perpetrator contribute to the review, and who should be responsible for facilitating their involvement? How will they be involved and contribute throughout the overall process taking account of the possible conflicting views within the family?
- How should matters concerning family and friends, the public and media be managed before, during and after the review, and who should take responsibility for this?
- Did the victim make a disclosure at work? Has the organisation a DA policy?
- Consideration should also be given to whether either the victim or the perpetrator was an 'adult at risk'; if this is the case, the review panel may require the assistance

or advice of additional appropriate agencies.

- How will agencies/professionals working in other local authority areas with an interest in the homicide be involved, including members of the local DA services and what should their roles and responsibilities be?
- Were the victim (and/or perpetrator) social housing tenants? If so was there rent arears or frequent repairs and maintenance requests? Have there been reports of anti-social behaviour at the property? Does the social housing landlord carry out routine screening for DA? Are there policies in place which support staff to identify and report suspected DA? Have the processes on place been reviewed to ensure that they remain effective?
- Who will make the link with relevant interested parties outside the main statutory agencies?
- How should the review process take account of previous lessons learned?
- Does the review panel need to obtain independent legal advice about any aspect of the proposed review?

The review panel chair is responsible for the final decision on the terms of reference and ensuring they are suitable and proportionate.

18. **Review Panel meeting structure and timescales**

As soon as the need for a DHR is established by the CSP, the review must be conducted expeditiously so that lessons are able to be drawn out which can be then be acted upon as quickly as possible.

The decision to conduct a DHR must be made within one month of the homicide/death coming to the attention of the CSP.

Following the decision, the DHR should then be completed within six months. It is accepted that some reviews will go beyond the six month timescale in circumstances of complex scope for the review or delayed and ongoing criminal proceedings.

Extending the timescale for completing a DHR must be agreed by the CSP and should also be referred to the Home Office Quality Assurance panel for further advice and notification.

The review itself will vary on a case by case basis, but will roughly follow the below structure in relation to panel meetings:

Stage 1:

- Introductions and a summary of the DHR process.
- Agencies will be asked to provide a short summary of their involvement in the case to provide context to the review and support the development of the terms of reference.
- The panel will discuss and agree the scope of the review and terms of reference; this will include agreeing the role of family and friends in feeding in to the review.
- Discuss and agree support for panel members.
- Discuss and agree with the chair the timescales for the next stages of the review.

Stage 2:

The next stage of the review process will vary in length dependent on the scale and scope of the review.

This stage is where the panel will review the agency-wide chronology and Individual Management Reviews (IMRs). The panel will have the IMRs presented by their authors and will discuss the key findings and agree the recommendations/lessons learnt for each agency.

The number of panel meetings will vary dependent on the number of IMRs commissioned for the review.

The views of the family and friends will be included in this section to support the panels' analysis of key findings.

Stage 3:

The independent chair will present the draft overview report to the panel for full discussion and suggest amendments.

The number of panel meetings will vary dependent on the number of amendments required of the report, but should be completed in no more than 3 panel meetings where possible.

The panel will then agree the final draft report and executive summary.

Stage 4:

The family will be given the opportunity to read the final overview report and if they wish to do so, meet the panel to share their thoughts and views.

Once the family has provided their feedback, the report will be finalised with agreement of the panel and submitted to the CSP for final sign off and submission to the Home Office.

The number of meetings in this stage will again vary dependent on the level of family involvement. The panel should be flexible and supportive in allowing the family adequate time to read the report and provide their thoughts and feedback on the review.

Appendix 8:11 provides a summary overview of the whole Gloucestershire DHR process.

As far as possible, the review should be conducted in such a way that the process is seen as a learning exercise and not as a way of apportioning blame.

19. **Chronology and Individual Management Reviews (IMRs)**

Those agencies identified as having involvement in the case will be required to complete an IMR for the review and a full chronology of their involvement in line with the terms of reference for the review.

When agencies are written to requesting their membership on the panel, agencies should also be requested to identify someone to produce the IMR and chronology.

This can be the same representative as the panel member, but agencies may decide to identify a different person to complete this detail.

The independent chair may commission additional IMRs from agencies who are not required as panel members. In these circumstances, the chair will write to senior

managers of organisations to commission the IMR.

The chronology from each agency will be merged in to a master chronology for the panel to consider the sequence of events and agency contact and identify key events in the life of the victim and perpetrator.

Appendix 8:12 provides a template chronology

The aim of the IMR is to:

- Allow agencies to look openly and critically at individual and organisational practice and the context within which professionals were working (culture, leadership, supervision, training etc.) to see whether the homicide indicates that practice needs to be changed or improved to support professionals to carry out their work to the highest standards.
- Identify how and when those changes or improvement will be brought about.
- Identify examples of good practice within agencies.

IMRs should be completed by someone who had no direct involvement with the victim, perpetrator or either families and should also not have been the immediate line manager of any staff involved.

All IMRs should be quality assured by the senior manager in the organisation who commissioned the report. This senior manager will be responsible for ensuring any recommendations in the IMR are appropriate and later acted upon appropriately.

When conducting an IMR, the IMR author may choose to interview staff members who had involvement in the case to support their assessment of agency involvement. Where interviews are conducted, this should be formally recorded and shared with the interviewee. These records should be retained for the purpose of disclosure to a criminal investigation should the need arise. Further detail on disclosure and criminal investigations can be found in section 9 of the Home Office statutory DHR guidance.

Once an IMR has been completed, agencies should develop an internal process for feeding back to any staff involved.

It is important to note that the DHR plays no role in disciplinary or complaints processes, although in some cases information may emerge that indicates that disciplinary action should be taken under that agencies established processes. Some DHRs may run alongside disciplinary or complaints processes for some agencies; this is a matter for individual agencies to manage within their own processes.

IMRs are presented to the DHR panel and will be discussed to agree on the final key findings, lessons learnt and recommendations.

Appendix 8:13 provides an IMR template

20. **Overview report**

The overview report will be completed by the independent chair, or report author where this is a separate individual. The report should bring together and draw overall conclusions from the information and analysis contained in the IMRs and other reports that have fed in to the review. Where necessary, further studies may be commissioned

to supplement the information available from the IMRs to better support conclusion and lessons learnt from the case.

The overview report should be produced in accordance with the format outlined in appendix 3 of the Home Office statutory DHR guidance.

The overview report should be regarded as 'Official' as per the Government Security Classification Scheme until the agreed date of publication. Prior to this, information should be made available only to participating professionals and their line managers who have a pre-declared interest in the review.

The review panel will have the overview report presented to them by the independent chair. On being presented with the report and its executive summary the review panel should:

- Ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the reports.
- Be satisfied that the reports accurately reflect the review panel's findings.
- Ensure that the reports have been written in accordance with the guidance.
- Be satisfied that the reports are of a sufficiently high standard for them to be submitted to the Home Office.

The final draft of the overview report should be provided to the family, giving them adequate time to consider and absorb the report, identify if any information has been incorrectly captured and record any areas of disagreement. It is recommended that the family are then given the opportunity to meet the review panel to discuss their thoughts on the report, and that the panel then consider the family input prior to agreeing the final version and submitting to the CSP.

21. **ActionPlan**

Within the overview report, recommendations for future actions will be made and agencies are required to translate these into specific measurable, achievable, realistic and timely (SMART) actions.

All DHRs must include a targeted and achievable action plan in which actions have been tested with the agency before the action plan is finalised and timeframes for completion should also be agreed at a senior level by each participating agency.

22. **Processfollowingcompletion**

22.1 **Role of CSP following completion of overview report, executive summary and action plan**

Upon receipt of the final documentation the CSP should:

- Agree the content of the overview report, executive summary and action plan, ensuring that they are fully anonymised apart from including the names of the review panel chair and panel members.
- Make arrangements to provide feedback and debriefing to staff, family members and the media as appropriate.
- Sign off the overview report, executive summary and action plan.

- Complete the form on page 41 of the Home Office DHR statutory guidance to assist in national data collection.
- Submit to entire DHR to the Home Office via secure email to: DHREnquiries@homeoffice.gsi.gov.uk
- Ensure that the documented are not published until clearance has been received by the Home Office Quality Assurance Panel.

In instances where the CSP wishes to make changes to the report, including the action plan, these should be referred back to the independent chair and review panel for consideration. The CSP should not look to influence the independence of the report by making its own recommendations without consultation with the review panel and chair; and as mentioned within 3.6 all agency actions must be approved by senior level staff in each organisation.

23. **Quality Assurance**

The Home Office Quality Assurance (QA) panel is made up of various experts from the statutory and voluntary sector who will assess all DHRs on a monthly basis for their compliance with the statutory guidance and assess report standards. The panel will also look to identify good practice and training needs.

The QA panel will look to ensure that the DHR demonstrates that:

- Areas have spoken with the appropriate agencies, voluntary and community sector organisations and family members and friends, to establish as full a picture as possible.
- The report demonstrates sufficient probing and analysis and the narrative is balanced.
- Lessons will be learnt and that areas have plans in place for ensuring this is the case.
- The likelihood of a repeat homicide is minimised.

Once the QA panel have reviewed the DHR, they will then write back to the CSP either making recommendations for change, or agreeing that the report is fit for publication.

If the QA panel requests changes to the report, the original panel should be made aware prior to publication. In circumstances where significant changes have been requested, it is advised that the panel be reconvened with the independent chair in order to review the changes requested.

The QA panel is also responsible for:

- Disseminating lesson learned and effective practice at a national level.
- Assessing progress at national level
- Identifying serious failings and common themes
- Communicating with media to raise awareness of the positive work of statutory and voluntary sector agencies.
- Communicating and liaising with other government departments to ensure appropriate engagement from all relevant agencies.
- Providing central storage of all DHRs to allow for clear auditing and quick retrieval.
- Reviewing decision by CSPs not to undertake a DHR.
- Recommending national training needs
- Recommending service needs to commissioners.

24. **Publication**

Once clearance has been received from the Home Office QA panel, the CSP must publish the overview report and executive summary on the local CSP website.

Section 2.9 provides guidance on the approach for media enquiries.

The chair of the review should also be made aware of the publication plans, and again, in high profile cases, be involved in the planning meeting.

The family should be provided with a copy of the overview report and letter from the Home Office QA panel. They should also be consulted to agree a publication date in order to avoid any significant dates for their family, and also to agree the approach with the media given they may also be approached for a statement.

Each participating agency should be provided with a copy of the report and action plan.

Once the report is published, the Home Office must be notified and provided with a link to the report via secure email: DHREnquiries@homeoffice.gsi.gov.uk

25. **Implementing the action plan**

It is the role of agencies to implement their actions within the deadline stated in the action plan.

The CSP is responsible for monitoring action plan completion and for holding agencies to account for actions that are either not completed or making limited progress.

DHR action plans will be monitored regularly at Safer Gloucestershire or Cheltenham CSP, and where possible (and when wanted by the family), updates on action progress will be given to the family to improve agency accountability.

The DHR cannot be formally concluded until the action plan has been fully implemented and audited by the CSP.

26. **Local Domestic Abuse Learning Reviews**

Where the death of a person does not meet this criteria, but where there is significant history of domestic abuse, CSPs can take the local decision to hold a learning review with the aim of:

- Establishing what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic abuse including their dependent children.
- Identifying clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.
- Applying these lessons to service responses including changes to policies and procedures as appropriate.
- Prevent domestic abuse and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

The learning review will differ from a DHR in that it will aim to be conducted in a workshop style; allowing agencies to share information relating to their involvement in the case, hold discussions and develop lessons learnt and action plans. The aim of this

workshop is to ensure learning from cases where a review would otherwise not be conducted, but where it is felt significant learning can be found that will improve service responses to victims of domestic abuse.

This approach can also be adopted for local 'near miss reviews' in which '*a domestic homicide was avoided through incident circumstance rather than through agency intervention to protect those involved'*. This will often involve a significant violent incident in which the victim has survived and where learning can be gained by agencies that were involved or should have been involved in the safeguarding of the victim.

27. **Criteria for a Domestic Abuse Learning Review**

The death of a person does not meet the criteria for a DHR on the basis that their death is not linked to their experience of violence, abuse or neglect, but where there is significant domestic abuse history that had a substantial and detrimental impact on their life and/or;

- There was evidence of a risk of serious harm to the victim that was not recognised or identified by the agencies in contact with the victim and/or the perpetrator, it was not shared with others and/or it was not acted upon in accordance with their recognised best professional practice.
- Any of the agencies or professionals involved considers that their concerns were not taken sufficiently seriously.
- The victim had little or no known contact with agencies but should have been known and supported.
- The death suggests that there have been failings in one or more aspects of the local operation of formal domestic violence and abuse procedures or other procedures for safeguarding adults.
- The victim was being managed by, or should have been referred to, a Multi- Agency Risk Assessment Conference (MARAC) or other multi-agency fora.
- The death appears to have implications/reputational issues for a range of agencies andprofessionals.
- The death suggests that national or local procedures or protocols may need to change or are not adequately understood or followed.
- The perpetrator holds a position of trust or authority e.g. police officer, social worker, health professional, and the homicide, therefore, is likely to have a significant impact on public confidence.
- Services were not available locally to refer/support the victim and/or the perpetrator

28. **Establishing a DA learning Review**

Any agency can identify a case to be considered for a learning review. Cases should be sent to the County Domestic Abuse and Sexual Violence Strategic Coordinator, who will then make contact with the relevant CSP to consider the case for review. A pool of local experts can be called upon to support decision making if required, as per local DHRguidance.

29. **Chairing arrangements**

As this process is not statutory, there is no need to commission an independent chair, unless considered necessary by the CSP. As such, a local decision can be taken as to

who is best placed to chair the learning review.

30. **Agency involvement**

Agencies will be invited to attend a 1 day learning review workshop and bring with them to the meeting;

A summary of their involvement with the victim, perpetrator and any children; recommended that they complete a short chronology that also considers;

- The events that occurred, the decisions made, and the actions taken or not. Assess practice against guidance and relevant legislation; see appendix A to support.
- Examples of effective and/or best practice
- Recommendations for improving future practice and how this can be actioned.

Agencies are also asked to be prepared to discuss and challenge one another and consider the voice of the victim.

31. **Accountability**

The review will be accountable to the Community Safety Partnership and any action to be taken following this review will be monitored by this group.

32. **Appendices**

The following appendices have been developed in a separate document:

- DHR checklist
- Domestic Abuse definition
- Summary of the role of CSPs
- Key contacts for CSPs
- Template DHR Notification Letter
- Template letter to inform agencies of the potential DHR
- Template letter to inform agencies of the confirmed DHR and commissioned chair
- Template contract for the independent chair
- Importance of family involvement summary
- Template letter to family members
- Summary DHR process flowchart
- Chronology template
- IMR template
- Family Advocacy Funding Agreement with AAFDA

All up to date templates and key agency contacts will be held by the County DASV Strategic Coordinator and Office for the Police and Crime Commissioner and will be available on request.

Appendix 9

Child Death Overview Panel Terms of Reference.

1. Purpose

Through a comprehensive and multidisciplinary review of child deaths, the Gloucestershire Safeguarding Children Executive (GSCE) CDOP aims to better understand how and why children in Gloucestershire die and use our findings to take action to prevent other deaths and improve the health and safety of our children.

In carrying out activities to pursue this purpose, the CDOP will meet the functions set out in Chapter 5 pg.95 of Working Together to Safeguard Children 2018 and Child Death Review Statutory and Operational Guidance (England) 2018 in relation to the deaths of any children normally resident in Gloucestershire. Namely collecting and analysing information about each death with a view to identifying –

(i) any case giving rise to the need for a Serious Case Review

(ii) any matters of concern affecting the safety and welfare of children in Gloucestershire

(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in Gloucestershire

2. Objectives

1. To ensure, in consultation with the local Coroner, that local procedures and protocols are developed, implemented and monitored, in line with the guidance as set out above on enquiring into unexpected deaths.
2. To ensure the accurate identification of and uniform, consistent reporting of the cause and manner of every child death.
3. To collect and collate an agreed minimum data set of information on all child deaths in Gloucestershire and, where relevant, to seek additional information from professionals and family members.
4. To evaluate data on the deaths of all children normally resident in Gloucestershire, thereby identifying lessons to be learnt or issues of concern, with a particular focus on holding the Child Death Review Team to account and effective inter agency working to safeguard and promote the welfare of children.
5. To evaluate specific cases in depth, where necessary to learn lessons or identify issues of concern.
6. To identify significant risk factors and trends in individual child deaths and in the overall patterns of deaths in Gloucestershire, including relevant environmental, social, health and cultural aspects of each death, and any systemic or structural factors affecting children's well-being to ensure a thorough consideration of how such deaths might be prevented in the future.
7. To identify any public health issues and consider, with the Director of Public Health and other provider services how best to address these and their implications for both the provision of services and for training.
8. To identify and advocate for needed changes in legislation, policy and practices to promote child health and safety and to prevent child deaths.
9. To increase public awareness and advocacy for the issues that affects the health and safety of children.

10. Where concerns of a criminal or child protection nature are identified, to ensure that the Police and Coroner are aware and to inform them of any specific new information that may influence their inquiries; to notify the GSCE of those concerns and advise on the need for further enquiries under section 47 of the Children Act, or of the need for Child Safeguarding Practice Reviews.
11. To improve agency responses to child deaths through monitoring the appropriateness of the response of professionals to each unexpected death of a child, reviewing the reports produced by the Joint Agency Response team and providing the professionals concerned with feedback on their work.
12. To provide relevant information to those professionals involved with the child's family so that they, in turn, can convey this information in a sensitive and timely manner to the family.
13. To monitor the support and assessment services offered to families of children who have died.
14. To monitor and advise the GSCE on the resources and training required locally to ensure an effective inter-agency response to child deaths.
15. To co-operate with any regional and national initiatives – e.g. the Confidential Enquiry into Maternal and Child Health (CEMACH).
16. Collation of data with neighbouring CDOP in Swindon and Wiltshire in order to identify lessons on the prevention of child deaths.
17. Establish shared learning opportunities with Swindon and Wiltshire CDOP.

3.**Scope**

The CDOP will gather and assess data on the deaths of all children from 24 weeks gestation (excluding those babies who are stillborn) up to the age of 18 years who are normally resident in Gloucestershire. This will include

1. **Unexpected Child Death** - An unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.

2. **Neonatal Child Death** - Any baby who dies that has not left hospital since birth. Note: Healthcare Safety Investigation Branch, HSIB investigation conducted separately and in parallel for Neonatal Death.

3. **Expected Child Death** – A child with a life limiting condition and not expected to survive more than 24 hours.

4. **Acute Life Threatening Event (ALTE)** – The unexpected collapse of a child where there is no known antecedent condition that might be expected to cause the collapse at that time. The child may, or may not, die immediately or subsequently from the consequences of the precipitating event or collapse.

Where a child normally resident in another area dies within Gloucestershire, that death shall be notified to the CDOP in the child's area of residence. Similarly, when a child normally resident in Gloucestershire dies outside Gloucestershire the Gloucestershire CDOP should be notified. In both cases an agreement should be made as to which CDOP (normally that of

the child's area of residence) will review the child's death and how they will report to the other.

Team Membership

The CDOP will have a permanent core membership drawn from the following key organisations represented on the GSCB and from other relevant organisations:

1. Consultant in Public Health – **Chair CDOP**
2. Children's Social Care – **Vice Chair CDOP**
3. Police Child Protection Unit
4. Designated Doctor for Child Death (CCG)
5. Health Partners – GRH (Midwifery), GCS, 2gether
6. Named GP
7. South West Ambulance Service Trust
8. Coroner's Office
9. CDOP Manager GSCE Support Unit Business Manager
10. Education
11. Lay representative/Faith community representative/Bereavement Counsellor
12. GSCE Support Unit Administration

CDOP core members will nominate a suitable deputy who will attend meetings in the absence of core members. (Not applicable for Lay group)

Other members may be co-opted to contribute to the discussion of certain types of death when they occur:

1. Emergency Department medical and nursing staff
2. Primary Care
3. Other paediatric input
4. Obstetric staff
5. Other Police representatives including accident investigators
6. Fire Services
7. Ambulance/paramedic services
8. Education
9. Paediatric Pathologist
10. Child and Adolescent Mental Health Services (CAMHS)
11. Adult mental health
12. University academic
13. Voluntary agencies
14. Registrar of Births, Deaths, Marriages
15. Community Safety
16. Others as required and agreed by the Chair

The Chair has the discretion to defer the meeting if the appropriate representatives or deputies, with relevant skill mix are not available for a meeting or there are insufficient numbers for the meeting to be held effectively.

Confidentiality and Information Sharing

Information discussed at the CDOP meetings will not be anonymised prior to the meeting, it is therefore essential that all members adhere to strict guidelines on confidentiality and

information sharing. Information is being shared in the public interest for the purposes set out in Working Together and is bound by legislation and data protection.

CDOP members will all be required to sign a confidentiality agreement (Appendix 1) before participating in the CDOP. Any ad-hoc or co-opted members and observers will also be required to sign the Confidentiality Agreement. At each meeting of the CDOP all participants will be required to sign an attendance sheet, confirming that they have understood and signed the Confidentiality Agreement.

Any reports, minutes and recommendations arising from the CDOP will be fully anonymised and steps taken to ensure that no personal information can be identified.

Accountabilityand Reporting arrangements
The CDOP will be accountable to the Gloucestershire Safeguarding Children Executive.

The CDOP is responsible for developing its work plan, which should be approved by the GSCE. UOB will prepare an Annual Report in conjunction with Swindon and Wiltshire CDOP for the GSCE, which is responsible for publishing relevant, anonymised information.

The GSCE takes responsibility for disseminating the lessons to be learnt to all relevant organisations and acts on any recommendations to improve policy, professional practice and inter-agency working to safeguard and promote the welfare of children.

All agencies represented on the CDOP must have in place pre-arranged 'Cascade' mechanisms for the dissemination of information

The GSCE via UOB will supply data regularly on every child death as required by the Department for Education and Skills to bodies commissioned by the Department to undertake and publish nationally comparable, anonymised analyses of these deaths.

Frequency of Meetings
The CDOP will in general meet at 2 monthly intervals but may hold extra meetings if matters are identified by the Chair of the panel or the GSCE which require an earlier response.

Administration
Meetings will be supported by the GSCE Safeguarding Support Unit Child Death Review CDOP Administrator following these basic principles

- minutes will be signed off by the CDOP Chair within 2 weeks of the meeting
- action points from the meeting will be shared with members within two weeks of the meeting
- agreed minutes will only be included in the papers distributed prior to the following meeting for agreement at that meeting
- all papers will be distributed no later than 7 days prior to the meeting that they relate to

Review
The Chair of the CDOP will ensure co-ordination with other working groups and will facilitate an annual review of these Terms of Reference and other associated documentation, amending as necessary.

Appendix 10

GloucestershireGSCE

Multi-Agency Case Review Subgroup Terms of Reference

1. **Role and Function of the Multi-Agency Case Review subgroup:**

To ensure that Gloucestershire Safeguarding Children Board is in a position to effectively learn lessons from all types of local case reviews, including Serious Case Reviews (SCRs) and to be in a position to effectively assist and monitor changes in working practices that arise from lessons from Serious Case Reviews and other reviews in order to improve outcomes for children and young people in Gloucestershire.

The members of the Multi-Agency Case Review Sub-Group have a responsibility to ensure that the requirements of the relevant statutory guidance (Working Together 2015) are met where a case meets the criteria for a serious case review; this is:

- For every case where abuse or neglect is known or suspected and either
  - A child dies; or
  - A child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

The group will receive cases for consideration from partner organisations and make recommendations to the Chair of GSCB as to whether the criteria are met.

Cases for consideration will also be received in relation to reviews of child protection incidents which fall below the threshold for a SCR. This is in line with Working Together 2015 which highlights that although these reviews are not required in statute they are important to provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children. They also provide opportunities to highlight good practice as well as identifying improvements that need to be made to local services.

2. **This will be achieved by:**

- Scrutinising available information about children who have died or been significantly harmed through abuse or neglect or serious incidents and making a recommendation to the Independent Chair of the GSCB about those children who may meet the criteria for a serious case review, on the need for a serious case review or other type of review;
- Commissioning Serious Case and other Reviews;
- Ensuring SCRs are conducted in accordance with current national advice and guidance;
- Ensuring that the most appropriate method of review is used in each case;
- Making decisions about serious incidents that give cause for concern but do not necessarily meet the criteria for a serious case review, including recommendations for a different kind of review (e.g. multi-agency review of a child protection incident, single agency reviews), and carrying out a full SCR if subsequently appropriate;
- Developing and implementing a range of methodologies to undertake learning reviews
- Ensuring that lessons learned from local and national reviews are disseminated to relevant staff in all local organisations through roadshows, feedback sessions, training courses or other activities to enable improvements to the Gloucestershire safeguarding system;

- Informing the Workforce Development Group of any identified training needs;
- Working with MAQuA to seek assurance that learning from reviews has resulted in evidence of improvements to practice and outcomes for children and young people.
- Working with the Communications Group in relation to disseminating the learning from SCRs and also in relation to media management relating to their publication;
- Providing training, guidance and tools to help staff from all partner agencies carry out SCRs and other reviews;
- Linking with the Child Death review process and receiving information in relation to unexpected child deaths and any subsequent learning

3. **Membership**

- Chief Inspector, Gloucestershire Constabulary – Chair
- Head of Service, Children's Social Care
- Head of Quality, Children's Social Care
- Named Nurse for Safeguarding, Gloucestershire Care Services
- Named Nurse for Safeguarding, 2gether NHS Foundation Trust
- Named Nurse for Safeguarding, Gloucestershire Clinical Commissioning Group
- Named Nurse for Safeguarding, Gloucestershire Hospitals NHS Foundation Trust
- Safeguarding Manager for Education
- Assistant Chief Officer, BGSW CRC
- Operations Manager, Youth Support Team
- Designated Doctor for Safeguarding
- Safeguarding Board Business Manager

If a core member of the sub-group is unable to attend they must arrange for a representative to attend of their behalf to ensure that decisions can be made in a timely way.

4. **Role of Chair**

- Lead and co-ordinate the work of the Subgroup
- Progress Safeguarding Business plan objectives
- To inform WFD of developments within the Safeguarding Board
- To take forward issues into the Safeguarding Board structure as appropriate
- Liaise with other areas WFD or Training Sub Groups
- Keep up to date with national and local developments in relation to safeguarding.
- Consultation with the Chairs of the other sub groups to ensure that professionals and staff from all agencies have the opportunity to familiarise themselves with the lessons arising from audits, reviews, communications and all other relevant updates.
- Provide reports for the Safeguarding Board meetings.
- Monitor agency attendance and compliance.

5. **Frequency of meetings:** Every 6 Weeks

Appendix 11

Terms of Reference Education and Learning Sub Group

1. **Role and Function of the Education and Learning Sub Group:**

   To ensure that all children and young people aged between 0 and 19 within any educational or training setting, including universal childcare remain safe.

2. **This will be achieved by:**

- Ensuring that all education, childcare and training providers for children and young people aged 0-19 and the education related services that support children outside of these settings have suitable policies and procedures in place to safeguard a child's wellbeing.
- Ensuring good communication and awareness amongst education, child care and training professionals of Gloucestershire's corporate policies and practices as well as the practices and procedures maintained and managed by the Gloucestershire Safeguarding Partnership on Child Protection and Children in Need.
- Taking forward practices set out by the Gloucestershire Safeguarding Partnership at local level and ensuring that they are being implemented in all relevant settings.
- Publicising National policies and cross agency child protection issues to promote awareness for all professionals in areas represented on the sub-committee.
- Working co-operatively with other agencies to establish and carry forward good practice and identifying areas of commonality to ensure the effective use of resources where possible.
- Overseeing the regular audit and monitoring aspects of safeguarding, to deliver single agency training and advice as appropriate and to keep records of training undertaken.
- Carrying out an annual audit of safeguarding issues within education, child care and learning settings (under Sections 175 and 157 of the Education Act 2002) in order to target provision aid policy-decisions and ensure settings are aware of changes within safeguarding.
- Acting as a conduit to service providers and the Gloucestershire Safeguarding Partnership by undertaking work requested by the Gloucestershire Safeguarding Partnership Executive Meeting and Board Meeting pertaining to safeguarding issues and reporting back progress made and any barriers to progress.
- Implementing our duty under sections 175 and 157 of the Education Act 2002 - 'Duties of LAs and Governing Bodies in relation to welfare of children' by ensuring arrangements are in place to safeguard and promote the welfare of children in educational settings and using these duties as a bench mark for agencies providing education and training for children and which are not covered by the Act.

3. **Membership**

- Chair, Education Safeguarding Manager
- Vice Chairs, Lead For GHLL
- Police
- Gloucestershire County Council
- The Diocese of Gloucester Academies Trust
- Gloucestershire Association of Special School Heads (GASSH)
- Gloucestershire Association of Primary School Heads (GAPH)

- Gloucestershire Association of Secondary Heads (GASH)
- IndependentSchools
- Gloucester Diocese
- Colleges
- Alternative Training Providers
- Novalis Trust
- Harrison Clark Rickerby Solicitors
- St. John's Ambulance
- Skillzone

4. **Role of Chair**

- Lead and co-ordinate the work of the Subgroup
- Progress Safeguarding Business plan objectives
- To inform WFD of developments within the Safeguarding Board
- To take forward issues into the Safeguarding Board structure as appropriate
- Liaise with other areas WFD or Training Sub Groups
- Keep up to date with national and local developments in relation to safeguarding.
- Consultation with the Chairs of the other sub groups to ensure that professionals and staff from all agencies have the opportunity to familiarise themselves with the lessons arising from audits, reviews, communications and all other relevant updates.
- Provide reports for the Safeguarding Board meetings.
- Monitor agency attendance and compliance.

5. **Frequency of meeting:** Minimum – every three months

Appendix 12

Workforce Development Sub Group (WFD) Terms of Reference

1. **Purpose:**

The purpose of this group is to ensure that the WFD Business Plan as agreed by the oard is implemented effectively across all partner agencies in Gloucestershire and recommendations on workforce development are made to the Board.

As part of the WFD Business Plan is the implementation of a Workforce Development Training and Evaluation Strategy to ensure that all workers in contact with children/young people and/or their parents and carers receive an appropriate level of training in Safeguarding children. This group will hold all agencies to account.

Agencies will identify a lead person for training on behalf of their agency to attend this group.

WFD will also;

- Agree effective quality assurance processes in order to ensure that the safeguarding children training provided by all member agencies meets approved standards.
- Provide feedback to the GSCB on areas requiring development or presenting challenge or concern.
- Offer guidance on the appropriate planning and delivery of safeguarding children training in order to ensure staff in all agencies are competent and confident to carry out their responsibilities for safeguarding and promoting the welfare of children and young people.
- Link to partner agencies training standard /competencies.

2. **Membership Responsibility**

- Commitment of 4 days per year, to include attendance at the 2 hour WFD meetings and other tasks as identified in order to fulfil aims and purpose of the group.
- If unable to attend scheduled WFD meetings, members will arrange for someone to attend on their behalf who has been briefed on pertinent issues for their agency and any significant developments or challenges.
- To undertake agreed tasks with regard to workforce development and training in their agency, e.g. providing evidence of quality assurance, content of training, aims and objectives etc. as required
- To keep up to date with new information, local and national research and guidance in relation to safeguarding children; in order to develop and maintain an advisory role with senior managers in their agency.
- To actively promote the importance of safeguarding children, learning and development and training within their own agency to support the development of best practice.
- To ensure that systems are available within their own agency to effectively disseminate information about safeguarding issues, learning and development events to all appropriate staff
- To ensure that managers and practitioners in their agency receive information from serious case reviews / case reviews,
- To support the implementation of the findings arising from serious case reviews, local inspections, audits and child death reviews; through training and learning events.

- To identify and share good practice in relation to safeguarding training learning and development, with other WFD members.
- Actively participate in the agenda and discussion, bringing safeguarding learning and development issues to and from their own agency
- To liaise with appropriate staff within their own agency and the GSCB training coordinator to facilitate any training audit and implement agreed quality assuranceprocesses.

3. **Membership:**

- Chair: CCG Designated Nurse for Safeguarding
- Vice Chair: Practice Development Manager
- Gloucestershire County Council
- Clinical Commissioning Group (CCG)
- NHS Hospital Trust
- Prospects (Youth Services)
- Gloucestershire Care Services
- 2gether NHS Trust
- Gloucestershire Fire and Rescue Service
- Police
- GSAB

4. **Role of Chair**

- Lead and co-ordinate the work of the Subgroup
- Progress Safeguarding Business plan objectives
- To inform WFD of developments within the Safeguarding Board
- To take forward issues into the Safeguarding Board structure as appropriate
- Liaise with other areas WFD or Training Sub Groups
- Keep up to date with national and local developments in relation to safeguarding.
- Consultation with the Chairs of the other sub groups to ensure that professionals and staff from all agencies have the opportunity to familiarise themselves with the lessons arising from audits, reviews, communications and all other relevant updates.
- Provide reports for the Safeguarding Board meetings.
- Monitor agency attendance and compliance.

5. **Frequency of Meetings:** Every 3 months

Appendix 13

Multi Agency Quality Assurance Sub Committee Terms of Reference

1. **Purpose:**

- To embed and strengthen the Quality Assurance Framework, in order to support their strategic oversight of effective safeguarding practice and support the GSCB Learning & Improvement Framework.
- To establish an annual timetable of Quality Assurance activity that supports the GSCB to prioritise and evaluate the effectiveness of safeguarding practice.
- To undertake in year multi-agency case audits, so that the GSCB can learn from good practice and areas for development evidenced at case level on themes as commissioned in the GSCB Annual Business Plan.
- To undertake multi-agency child protection reflective learning circles and report on key themes so that the GSCB can learn from practitioners' experiences and areas for development evidenced at case level.
- To liaise with the Serious Case Review Sub Group to ensure the monitoring and evaluation of recommendations or findings from case reviews that may be undertaken when a case doesn't meet the criteria for commissioning a Serious Case Review.
- To co-ordinate the production and analysis of multi-agency safeguarding performance data, in order to provide the GSCB with a quarterly performance report.
- To develop the performance report to be increasingly qualitative and outcome focussed, to support the GSCB strategic understanding and oversight of "how effective are partners both individually and collectively, in safeguarding children and young people?"
- To co-ordinate the production and analysis of partner agencies Section 11 of the Children Act self-assessments, in order to support the GSCB identifying strengths and areas for development and from these, robust scrutiny of improvement actions taken.
- To consider feedback from Section 175 self-assessments undertaken by education settings and analysed by the Education & Learning Forum, in order to ensure that GSCB Quality Assurance activity is informed by the arising trends and themes.
- To analyse information on complaints about partnership safeguarding work by a) children, young people or parents and b) professionals who use the "problem resolution protocol" or other Quality Assurance feedback mechanisms, in order to support shared learning and development of partnership work.
- To maintain oversight of single agency audit findings in relation to safeguarding children.

2. **Membership:**

- Gloucestershire County Council
- Clinical Commissioning Group
- NHS Hospital Trust
- Gloucestershire Hospital NHS Foundation Trust (GHNHSFT)
- Prospects (Youth Services)
- Gloucestershire Care Services
- 2gether NHS Trust
- Police

3. **Role of Chair**

- Lead and co-ordinate the work of the Subgroup
- Progress Safeguarding Business plan objectives
- To inform WFD of developments within the Safeguarding Board
- To take forward issues into the Safeguarding Board structure as appropriate
- Liaise with other areas WFD or Training Sub Groups
- Keep up to date with national and local developments in relation to safeguarding.
- Consultation with the Chairs of the other sub groups to ensure that professionals and staff from all agencies have the opportunity to familiarise themselves with the lessons arising from audits, reviews, communications and all other relevant updates.
- Provide reports for the Safeguarding Board meetings.
- Monitor agency attendance and compliance.

4. **Frequency of meetings:** Every 3 Months

Appendix 14

Multi-agency training and learning opportunities for all staff working with children, young people and their families in Gloucestershire.

Training Programme April 2018 – March 2020

https://www.gscb.org.uk/safeguarding-training-development-and-events/

1. **Introduction**

Learning and development, training offer 2018 – 2020

The Safeguarding Board has a statutory responsibility to support the development of policies and procedures in respect of training and to ensure that appropriate learning and training opportunities are provided for people who work with children, young people and their families, to meet local need. Consequently the Workforce Development (WFD) sub group are charged with this responsibility. Through the transition into WT2018 the WFD Sub group will maintain the oversight of the training offered and ensure continuity of delivery and development.

'Working Together to Safeguard Children (WT2015) enforces the functions of LSCBs under Regulation 5 (1a)(ii) in relation to:

" training of persons who work with children or in services affecting the safety and welfare of children

Reg. 5 (2)

" *monitor and evaluate the effectiveness of training, including multi-agency training,*

to safeguard and promote the welfare of children"

The Board is committed to supporting the delivery of high quality training, and to ensure all training is monitored and evaluated to maintain the effectiveness of this training, in order to safeguard and promote the welfare of children and young people.

The Training Strategy and Training Evaluation and Impact Framework sets out how we can achieve this; the board further seeks to learn from local serious case reviews, case file audits and emerging local trends.

https://www.gscb.org.uk/safeguarding-training-development-and-events/training-strategy/

The Safeguarding Board business unit offers a core programme of training courses on a rolling programme of events, with a clearly outlined charging and cancellation policy and on-line booking facility. It also offers a suite of e-learning courses some of which are soon to move to a new provider.

Throughout the year the Safeguarding Board also offer additional learning opportunities in the form of thematic locality based workshops, serious incident learning reviews and conferences. These events are promoted via the Safeguarding Board Alert system, through targeted campaigns to encourage those groups of people identified that would most benefit from specific learning; and through those senior managers represented at Board and sub group level.

2. **What you need to know about Safeguarding Boards training courses**:

https://www.gscb.org.uk/safeguarding-training-development-and-events/what-you-need- to-know-about-gscb-training-courses/

(Full details & all you need to know about our training and recommendations)

3. **Levels of training and required training**

The training pathway sets out the level of training required for all groups of staff working with children, young people and their families according to their job role and responsibility.

- **Level 1 (Group 1)** For staff in infrequent contact with children/young people and/or parents/carers who may become aware of possible abuse or neglect e.g. GP Receptionists, librarians, groundsmen,
  - Induction / Basic safeguarding awareness:
  - Single Agency Training – Delivered by agencies in-house (e-learning / face to face)
- **Level 2 (Group 2)** Those in regular contact or have a period of intense but irregular contact with children, young people and/or parents/carers including all health clinical staff, who may be in a position to identify concerns about maltreatment.
  - Introduction / Revision of working together to safeguard children
  - Single Agency Training – Delivered by agencies in-house (e-learning / face to face)
- **Multi-agency Training Offer**
  https://www.gscb.org.uk/safeguarding-training-development-and-events/
  - **Level 3 (Group 3)** Members of the workforce who work predominantly with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and reviewing the needs of a child and parenting capacity where there are safeguarding concerns. Also those staff managing this area of the workforce, newly qualified staff and those new to Gloucestershire.
    - Inter-agency child protection (1 day)
    - Inter-agency revision and update (½ day)
  - **Level 4 - 8 (Group 4-8) Specialist courses** Members of the workforce who have particular responsibilities in relation to undertaking section 47 enquiries, including professionals from health, education, police and children's social care; those who work with complex cases in specialist areas, named professionals and designated lead professionals, operational managers at all levels, senior managers.
    - Specialist Advanced Practitioner (2 day)
    - Working Together in Child Protection Conferences and Core Groups (1/2 day)
    - Domestic Abuse (Safeguarding children) (2 day)
    - Domestic Abuse (Advanced) (1 day)
    - Child Sexual Exploitation (CSE) (1 day)
    - Female Genital Mutilation (FGM), Honour Based Violence (HBV), Forced Marriage (FM) (1 day)
    - Safeguarding Disabled Children and YP (2 day)
    - Parental Substance Misuse (Impact on children) (1 day)
    - Parental Mental Ill Health (Impact on children) (1 day)
    - Working with Father to Safeguard Children (1 day)
    - Understanding Sexual Violence to Safeguard CYP & Adults (1 day)
    - Young People at risk of Substance Misuse (1 day) and (2 hour-Twilight sessions in schools)
    - Safer Recruitment Training (1/2 day)

- Safer Working Practices (1/2 day)
- **Train The Trainer Programme**_Delegates completing this programme are required to attend: 3 days training, 2-3 hours trainer observations, reflection and satisfactory completion of workbooks; they are offered on-going support and mentoring over a period of 6 to 9 months.
- **Child Neglect Toolkit training**_(½ day)The Business Unit: supports the child neglect toolkit training delivered by partner agencies (GCC Early Help- Community Social Workers and GCS Specialist Health Nurses)
- **Early Years sector Safeguarding Children training** The Business Unit offers multi-agency (level 3) and single agency (level 2) safeguarding children training to all of the Early Years sector, this includes early years settings, nurseries, registered child minders and childminder assistants.

  Further information available: https://www.gscb.org.uk/safeguarding-training-development-and-events/early-years-single-agency-training/
- Thematic learning Events and Roadshows Every year the Business unit identifies a series of workshops, thematic roadshows, and learning events as directed by the work of the board and its sub groups, on current local and National emerging themes.
- **Learning from SCR'S** This year there have been a number of learning events strictly for those partners involved in current and on-going local SCR's; further bespoke workshops, Information Newsletters and Alerts will be promoted following publication of these SCR's.
- **DASH training** In the summer of 2018, a series of 8 half day workshops were rolled out to all partner agencies and in particular Social Workers, Health, and Police on: Domestic Abuse, Coercive Control and use of the DASH risk assessment tool and Young Persons DASH. An emerging theme had been identified that suggested agencies were not sure who and how to use these tools. Therefore the workshops were able to cover these concerns and the use and role of the Police VIST system.
- **Child Neglect training** In 2017 the Business supported partners in the development and launch of a 'Gloucestershire Child Neglect Strategy', training and Conference and continues to support the Early Help Neglect training.

  Further Child Neglect workshops (½ day) sessions are now planned to begin in March 2019 to reach a wider audience across the county. These learning events will include current thinking on child neglect, the themes arising from current local SCR's, DHR's and reviews, and will identify best practice in Gloucestershire and practical tools (Neglect Toolkit) to support practitioners.
- **Non Accidental Injuries Learning Event** The Business unit supported this event in January 2019, which looked at the increased number of non-accidental injuries in non-mobile babies and young children in Gloucestershire; and at two recent local cases. This was a full day of learning and sought to look at immediate ways of improving the systems, policies and practices in county in order to safeguard these children.

4. Measuring the Impact of learning and development

All of the multi-agency training offered on behalf of the Safeguarding Board are evaluated and measured both in quantity and quality this is in the form of Pre – course and Post – course questionnaire style evaluations and three monthly questionnaires to look at impact. This information is reported to the Workforce Development Group quarterly and to the Board through training reports and the Boards Annual Report.

Delegates report high satisfaction in the quality of the courses delivered and impact evaluations evidence impact in practice.

A recent single agency review of all multi-agency training courses observed over a period of nine months, in the training year 2018 – 2019; has just been completed (Dec 2018). The report offers area's of improvement but is overwhelmingly positive in terms of the quality of the courses.

The report concluded that the multi-agency training offer;

…..*"gives Health Visitors within Gloucestershire Care Services the skills and knowledge needed to safeguard children and promote the welfare of children"*

5. **Numbers of staff trained**

The Safeguarding Board were able to report in last year's Annual Report (2017 to 2018), that across all the training activity delivered on behalf of the Board, 189 learning and training events were delivered and almost 4,400 staff were trained (not including e-learning courses).

Figures for the year (2018 to 2019) would suggest a similar number of staff taking up the training offer; however there continues to be a low rate of take up from some of the main statutory agencies i.e. Police and Probation and numbers from children social care is often inconsistent.

The Business unit is involved in supporting all partner agencies in their own learning and developments events throughout the year, Schools and GP Forums, Early Years and Health Conferences, Children Social Care and Police learning events and more

Appendix 15

Allegations Management

Concern about a member of staff or a volunteer working with children

If a professional receives an allegation or has a concern about the behaviour of a member of staff working or volunteering with children and that concern could amount to:

a. a member of staff or volunteer has behaved in a way that has harmed a child, or may have harmed a child, or
b. possibly committed a criminal offence against or related to a child, or
c. behaved towards a child or children in a way that indicates s/he may pose a risk of harm to children.

Then that professional should:

↓

Report their concerns

Report the concern to the most senior person not implicated in the allegation.

↓

Completion of written record

Complete a written record of the nature and circumstances surrounding the concern, including any previous concerns help. Include where the concern came from and brief details only.

↓

Seek advice before proceeding – Initial Discussion

Always contact the Local Authority Designated Officer (LADO) for advice prior to investigating the allegation. This is because it might meet the criminal threshold and so your investigation could interfere with a Police or Social Care investigation.

Local Authority Designated Officer (LADO) – Tel: 01452 426994

The LADO will offer advice on any immediate action required and will assist with employment and safeguarding issues.

↓

Allegations Management Process

If, after your Initial Discussion with the LADO, it is agreed that the allegation meets the criteria, a multi-agency meeting will be convened and you will be invited. This might result in a criminal investigation, a Social Care investigation and/or an investigation to inform whether disciplinary action is required.

If it is agreed that the allegation does not meet the criteria, the LADO will record the Initial Discussion and send it to you for your records. Any further action will be taken within your setting if necessary.

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Further action

Further meetings might be required and these will be convened by the LADO, with your input at all times. Further information on the Allegations Management process can be found in the Government Document: Working Together to Safeguard Children 2015 and the South West Procedures.

http://www.proceduresonline.com/swcpp/gloucestershire/p_alleg_against_staff.html


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COUNTY COUNCIL


NHS
Gloucestershire
Clinical Commissioning Group