#### Background

Alex and her family have been intermittently subject to child protection plans since birth.

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# ۲ic ۲ Safeguarding concerns Concerns had been raised about parental domestic abuse and drug use and its impact on the children in the household including neglect.

· Identify and outline the steps you and your team will take to improve practice in line with the findings and recommendations.

## 06

Tameside

Safeguarding

Children Partnership

#### Recommendations

• The partnership should seek assurance that the GCP training package is completed, evaluated and embedded into practice. • The Partnership should ensure that consultation is had with a number of GPs to gain an improved understanding of the GP roles and responsibilities to improve partnership working. Multi-agency audit reviewing strategy meetings needs to be undertaken. • TSCP should seek assurance from partner agencies that

staff are being reminded to fully explore the lived experience of a child and to include their findings in all records including assessments, alongside the voice of the child TSCP should contact the service manager at Salford Safeguarding Unit to discuss their Child Protection re-referral and step down processes and consider adopting the same or similar procedures. • TCSP and partner agencies should consider developing a parent advocate scheme to support families coming to conference.

Alex

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The review The review identified the following key themes: Strategy Meetings Graded Care Profile • Voice of the Child and Lived Experience

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The incident

School's attention was brought to an intimate

photo of Alex, circulated on social media showing Alex with an older male. School

contacted Alex's parents, advising them to

contact the police. Allegations of historical

rape were then made and referral was made to

Children's Social Care.

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• Information Sharing with GP Surgeries

Signs of Safety

#### The findings

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· Lack of knowledge from Professionals from all agencies of the benefit of strategy meetings. Strategy meetings are not consistently held in accordance with Working Together including attendance at meetings. • The Graded Care Profile is not effectively used by practitioners. Advice of managers/supervisors is not sought. Staff resources did not allow for the social worker to be best matched to the child's circumstances. • Professionals are not consistently hearing a child's voice and learning of their lived experiences. · Professionals are not consistently including the voice and lived experiences of young, non-verbal children in assessments. There is not enough multi agency understanding of the GP role and responsibilities to establish what agencies can reasonably expect of their safeguarding processes. · Professionals have some concerns regarding the success of the Signs of Safety model and its use in practice. · An audit needs to be undertaken to understand why children are being re-referred to services.

07 7 Minute 03 **Briefing** 06 NA 05

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Link to Published Case review: Ben and Alex

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Name of Organisation	Team Manager

Name of Section & Team	
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Contact Details .....

### Identify the learning or recommendations that are relevant to your team and summarise your teams' discussion on those points

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2.			
3.			



Please ensure you keep a copy of this discussion and plan for your records. Tameside Safeguarding Children Partnership will ask teams to provide evidence of the discussion, agreed actions and for evidence of improvements to practice.



### What actions have been agreed to improve practice?

What needs to happen?	Who will do it?	By When?	How will you know when it has been done?	How will you know if it has worked?



Please ensure you keep a copy of this discussion and plan for your records. Tameside Safeguarding Children Partnership will ask teams to provide evidence of the discussion, agreed actions and for evidence of improvements to practice.

**D1**