Background

Q22 is 17 years old. She lived with her father but had been accommodated on a number of occasions by the local authority. Q22's father raised his concerns about the protection of his daughter who was at risk of harm from child exploitation. Q22 had a diagnosis of ADHD. She had accessed mental health services and was thought to have behavioural difficulties at school.

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Safeguarding concerns

Q22 had in the past been subject to a child protection care plan under the category of emotional abuse. Her father recently raised a number of concerns about support from services for Q22. Q22 had been receiving support from the complex safeguarding team due to a number of concerns about child sexual exploitation. She regularly went missing for long periods of time.

Implementing Change Reflect on the findings and

discuss the implications for your service/practice. Identify and outline the steps you and your team will take to improve practice in line with the findings and recommendations.

06

Recommendations

A task and finish multi-agency group, a work stream of the Complex Safeguarding is to be identified to undertake the following work:

• Ensuring that Tameside Multi agency services are compliant with the recommendations as per national panel review of complex safeguarding "In Plain Sight" and "It's Hard to Escape"

- Recurrent themes and learning of local rapid reviews and local child safeguarding practice reviews are embedded into multi agency safeguarding practice in Tameside.
- Agencies need to ensure that their workforce have skills to respectfully challenge families where non -engagement with services is impacting on children and young people receiving support and protection
- Agencies need to ensure that they are able to consider alternative approaches to the engagement of children and young people.
 - Agencies need to ensure that there is capacity within multi-agency safeguarding services to respond to children and young people who are at risk of harm from complex safeguarding.
 - A Practitioner Event must be held to share the learning from complex safeguarding reviews directly with practitioners

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The incident

Q22 was arrested with an adult male after Police pursuit of a car. She had been missing from home for a sustained period of time.

The review

The review focused on the following:

- Coordinated multi-agency action
 - plan Working with hard to reach children
 - In stability of multi-agency care plans

05

Q22

05

02

The findings

There was evidence of a significant amount of multi-agency good practice for information sharing and trying to reach out to Q22

- Lack of multi-agency coordination of the work undertaken with Q22
 - Placements allocated in response to a crisis rather than pre planned to meet Q22's needs

7 Minute 03 07 **Briefing** 06

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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

1.			
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.