Telford and Wrekin Safeguarding PARTNERSHIP

Training Offer 2025 – 2026

"Empowering agencies, protecting communities:

Learning that safeguards every child"

West Mercia Police

Integrated Care System
Shropshire, Telford and Wrekin

Telford & Wrekin COUNCIL

Telford and Wrekin Safeguarding PARTNERSHIP

Our Mission

Our training offer provides high-quality, multi-agency safeguarding learning opportunities designed to strengthen practice and improve outcomes for children, young people and adults at risk. Through a comprehensive programme of courses, workshops and resources, we aim to equip professionals with the knowledge, skills and confidence to identify, respond to and prevent harm effectively. The training is aligned with statutory guidance and local priorities, ensuring that all agencies work collaboratively to uphold the highest standards of safeguarding across Telford and Wrekin.

West Mercia Police

Integrated Care System
Shropshire, Telford and Wrekin

Telford & Wrekin Council

Menu

- Training
- Learning from SARs
- Learning from DHRs
- Learning from CSPRs
- 7-minute briefings
- Toolkits & Best Practice Guidance

Telford and Wrekin Safeguarding PARTNERSHIP

Telford and Wrekin Safeguarding PARTNERSHIP

See what's available per month

(Interactive page which would link)

January 2026	February 2026	March 2026
April 2026	May 2026	June 2026
July 2026	August 2026	September 2026
October 2026	November 2026	December 2026

Telford and Wrekin Safeguarding PARTNERSHIP

Training Brochure

Back to Basics Training

The Back-to-Basics training is designed to strengthen good practice across the child protection system, guiding professionals through the safeguarding pathway from referral to child protection conferences and planning. Its aim is to improve outcomes for children and families by building confidence, clarity of roles, and professional curiosity in multi-agency practice.

How to book: Scan QR code to access Eventbrite

BACK« TO BASICS

Multi-agency workshop

The child protection system, processes and activity (including Position of Trust meetings)

» 26 March 2026 9.30am – 12.30pm
The Quad, Station Quarter, Ironmasters Way, Telford TF3 4NT

The overarching aim of this workshop is to improve safeguarding outcomes for children and young people in Telford.

For children and their families to be supported well through the child protection system both emotionally and practically.

For all professionals involved in child protection across the partnership to understand the child protection system and be confident in their roles, understanding well their responsibilities and that of their colleagues.

To be/remain a professionally curious participant throughout all the various processes in the child protection system and to know how to, and be able to, confidently challenge when needing to do so in the best interests of children.

This workshop will support you to be Working Together 2023 and TWCSP compliant and is aligned with the Family First Programme.

Click or scan the QR code to book your place

BACK« TO BASICS

Multi-agency workshop

Child Protection Conferences and Child Protection Planning

» 30 April 2026 9.30am – 12.30pm
Meeting Point House Octagon Room

The objective of this workshop includes to understand the thresholds for child protection planning, to know how to write effective Child Protection Reports and plans, to understand your role in Child Protection Conferences and Core Groups and to feel confident in participation and decision making.

We will do this by exploring:

- principles of supporting children and families and the child protection system;
- the purpose of Conferences /Core Groups meetings, what they need to achieve and how to get there;
- understanding of your role and those of others;
- preparing for meetings;
- the expectations of attending professionals ie the Lead Professional/Chairperson (behaviour and responsibility);
- analysis/decision making and working with the notion of significant harm, significant impairment and child in need; and
- professional curiosity – including professional challenge and escalation.

This workshop will support you to be Working Together 2023 and TWCSP compliant and is aligned with the Family First Programme.

Click or scan the QR code to book your place

Motivational Interviewing

3 March 2026 9.30am – 1pm
The Quad, Station Quarter, Ironmasters Way, Telford, TF3 4NT

This workshop provides an overview of the theory and practice of Motivational Interviewing (MI) and its application in direct practice.

It will explore the ethos, values, and principles of MI, including how relational and trauma-informed approaches can enhance practice. The session will also consider presenting needs within this context and incorporate systemic principles to strengthen our work.

Click or scan the QR code to book your place

Introduction to Systemic Practice

11 March 2026 9.30am – 12.30pm
Meeting Point House Octagon Room

This is a workshop session exploring the principles of systemic practice and how they relate to Children's Social Work.

This workshop will introduce key systemic concepts, focusing on how relationships, patterns, and contexts shape our work with individuals, families, and teams. We will look at the approaches, methods and techniques of Systemic Practice and discuss practical insights to enhance collaboration and understanding across disciplines and agencies.

Click or scan the QR code to book your place

TWSP Threshold Guidance including Early Help Assessment and Support Plan briefing

This training provides an overview of Telford & Wrekin Safeguarding Partnership (TWSP) Threshold Guidance, explaining how to identify levels of need and risk and how to use the Early Help Assessment and Support Plan to coordinate timely, appropriate support for children and families.

Date	Time
Meeting Point House, Telford	
5th February 2026	**10:00-13:00**
11th May 2026	**10:00-13:00**
18th September 2026	**10:00-13:00**
3rd December 2026	**10:00-13:00**
Follow the link to book:	
TWSP Threshold Guidance including Early Help Assessment and Support Plan briefing : TWSP Threshold Guidance including Early Help Assessment and Support Plan briefing	

Managing Allegations LADO

This training covers how to manage and respond to allegations against individuals working with children, following statutory guidance and the Local Authority Designated Officer (LADO) process to ensure safe, fair and consistent handling of concerns.

Date	Time
Meeting Point House, Telford	
2nd March 2026	**09:00-13:00**
1st June 2026	**14:00-17:00**
7th September 2026	**14:00-17:00**
7th December 2026	**09:00-13:00**
Follow the link to book:	
Course: Managing Allegations (LADO)	

Raising Awareness of Private Fostering

The Telford and Wrekin Safeguarding Partnership(TWSP) Raising Awareness of Private Fostering training provides a brief overview of what private fostering is, the legal requirements for notification, and the responsibilities of professionals in identifying and reporting private fostering arrangements to safeguard children.

Date	Time
Microsoft Teams	
9th January 2026	**12:00-13:00**
18th March 2026	**10:00-11:00**
14th May 2026	**15:00-16:00**
10th July 2026	**12:00-13:00**
16th September 2026	**17:00-18:00**
6th November 2026	**09:30-10:30**
Follow the link to book:	
TWSP Raising Awareness of Private Fostering Briefing	

Raising Awareness of Exploitation and Vulnerability

The Raising Awareness of Exploitation and Vulnerability training helps professionals understand different forms of exploitation, recognise indicators of vulnerability and learn how to respond effectively to protect children and young people.

Date	Time
Microsoft Teams	
22nd January 2026	**09:00-11:00**
21st April 2026	**10:00-12:00**
6th July 2026	**12:00-14:00**
1st October 2026	**11:00-13:00**
15th December 2026	**10:00-12:00**
Follow the link to book:	
TWSP Raising Awareness of Exploitation and Vulnerability	

Brook Traffic Light Tool

The TWSP Brook Traffic Light Tool training teaches professionals how to use the Brook Traffic Light System to identify, assess and respond appropriately to sexual behaviours in children and young people, distinguishing between healthy, concerning and harmful behaviours.

Date	Time
Meeting Point House	
20th January 2026	**09:00-13:00**
Microsoft Teams	
3rd March 2026	**18:00-20:00**
17th March 2026	**18:00-20:00**
(Both online sessions must be attended)	
Follow the link to book:	
TWSP - Brook Traffic Light Tool	

Telford and Wrekin Safeguarding PARTNERSHIP

Understanding SARC Services and Support

Discover the vital support and specialist services SARC provides for individuals affected by sexual assault, including medical care, advocacy and referral pathways. Learn how you can access these services and strengthen multi-agency safeguarding responses.

Delivered by Martyne Roberts

Date	Time
Microsoft Teams	
Dates and times to be confirmed in 2026	
To book a place email:	
Partnerships@telford.gov.uk	

Raising Critical Consciousness and Strengthening Culturally aware practice with Children and Families

Aims:
1. Understand the problem
Recognise how culturally unaware practice and systemic bias impact relationships, decision-making and outcomes in working with Children and Families.

2. Raising consciousness
Increase awareness of personal and structural biases and practice techniques to notice and interrupt these.

3. Strengthen practice
Apply evidence-based frameworks and tools to support culturally curious and aware practice embedding anti oppressive practice in everyday decision making.

Date	Time
Microsoft Teams	
30th January 2026	09:30-11:30
12th March 2026	09:30-11:30
Email to book:	
Partnerships@telford.gov.uk	

Family First Programme

The Families First Partnership (FFP) Programme is a UK government guidance aimed at reforming children's social care by creating a more joined-up, family-focused system of support.

The FFP Programme helps local safeguarding partners (like social care, health, and police) work together to deliver early, targeted support to families through:

- Family Help services
- Multi-agency child protection
- Family Group Decision Making.

Its goal is to ensure families get the right help at the right time, keeping children safe and improving long-term outcomes.

National reviews have driven a commitment to reform, with Families First acting as the delivery programme to embed these changes locally. It aims to create a more responsive, relational, and preventative system—one that reflects the values of Telford & Wrekin's Family First Approach.

The Government has published guidance about how the Families First Programme should be taken forward by Local Authorities including some minimum expectations.

As this programme rolls out there shall be further training offered across the Partnership which shall be advertised through the Telford and Wrekin Safeguarding Partnership.

- **Further reading:** The Families First Partnership (FFP) Programme Guide

Kinship Local Offer Training

Do you work with children and families in Telford and Wrekin?

This online training session is designed to help professionals understand and support kinship families effectively.

Kinship care is when a child is raised by relatives or close family friends due to circumstances where their parents are unable to care for them. These families often face unique challenges and may not be aware of the support available to them.

This session will cover:

What kinship care is

The support available locally through the Kinship Local Offer

Key contacts and how to signpost families to the right services

You will also hear from a kinship carer (their journey and experiences)

Date	Time
Microsoft Teams	
18th December 2025	12:00-13:00
20th January 2026	16:00-17:00
18th February 2026	11:00-12:00
6th March 2026	13:00-14:00
Email to book:	
Partnerships@telford.gov.uk	

Circle of Support

The Circle of Support is a family-led decision-making process that brings together the child's wider network of family, friends, and trusted individuals to create safe, sustainable plans for the child's care and wellbeing. It empowers families to take the lead, strengthens relationships, and respects cultural identity and family values. The goal is to keep children within their communities and prevent unnecessary formal care arrangements by collaboratively finding practical solutions.

Training focuses on:

- Understanding the principles and values of FGDM, including family empowerment and collaborative planning.
- How to prepare and facilitate Circle of Support meetings effectively.
- Skills for engaging families early, mapping support networks, and creating inclusive spaces.
- Practical steps for developing plans that address safeguarding concerns and strengthen family resilience.
- Cultural sensitivity and strategies for involving children and their advocates appropriately.

Date	Time
Quad (TBC)	
Target audience: Duty Assessment/Cate/ Family Safeguarding/Family Hubs/Fostering (Education 20 delegates)	
26th February 2026	09:00-16:00
27th February 2026	09:00-16:00
Email to book:	
Partnerships@telford.gov.uk	

Strengthening multi-agency leadership in responding to intra-familial child sexual abuse

Centre of expertise on child sexual abuse

Workshop one: Strategic planning

Presented by: Dr Natasha Sabin and Jenny Coles

Date: 14th January 2026

Time: 13:00 to 14:30

Workshop two: Professional knowledge, skills and confidence

Presented by: Anna Glinski and Lorraine Myles

Date: 3rd February 2026

Time: 13:00 to 14:30

Workshop three: Enquiries and investigations

Presented by: Paul Burnside and Nick Connaughton

Date: 12th March 2026

Time: 10:00 to 11:30

Workshop four: Assessment of people presenting risk of sexual harm

Presented by: Anna Glinski, TJ Abrahams, and Becky Canning

Date: 21st May 2026

Time: 10:00 to 11:30

Workshop five: Talking to children

Presented by: Lorraine Myles and Dr Natasha Sabin

Date: 17th June 2026

Time: 10:00 to 11:30

Workshop six: Health

Presented by: Nici Evans and Dr Alison Steele

Date: 13th July 2025

Time: 13:00 to 14:30

To book: https://www.csacentre.org.uk/training-events/strengthening-multi-agency-leadership-webinar-series/

AXIS

Supporting Survivors of Sexual Abuse

Introduction to sexual violence/abuse

Aim of the course

Identify a clear definition of “Sexual violence/abuse”.

Explain what the role of an ISVA is in relation to victims/survivors of sexual violence/abuse.

Be able to dispel some of the myths around sexual violence/abuse.

Identify the impact of sexual violence/abuse on the victim and their family.

Understand the definition of consent.

Identify the signs of sexual abuse.

Understand the importance of communicating and responding to concerns of sexual violence/abuse.

Be able to explain the does and don’ts when interacting with victims of

Our introductory course is a free 3-hour session, delivered face to face, we can come to your organisation, or you can book through joint training.

For more information on the above course, please do contact Dawn Shanahan on the following email address, or call the number below.

training@axiscounselling.org.uk

Open Access

Our open access training programme provides free, high-quality safeguarding learning opportunities for professionals and volunteers across Telford and Wrekin, drawing on expertise and resources from neighbouring partnerships to ensure a comprehensive and collaborative approach.

Open access learning links

Professional Curiosity Toolskit	SAB Network /TWSP
Listen Learn Lead	Make It Real
Who Cares for the Carers Seminar	T&W Council
Domestic Abuse	West Mercia
Neglect Webinar	West Midlands Regional
Predatory Marriage	Our Story
Adults at risk of harm due to fire	Walsall Saffeguarding
Pressure Ulcers	Telford Viability
Mental Capacity	Shropshire Council
Abuse and Exploitation	Telford & Shropshire Partnership
FGM	Virtual College
Home Office Prevent	Home Office
Understanding DBS	Telford and Wrekin
Trauma & the brain	West Midlands
The importance of robust recording	Safeguarding Association
Suicide Prevention Awareness	Papyrus
Online Safety Webinars for Schools	NSPCC
Mandatory Reporting Child Sexual Abuse	NSPCC
ACEs training £5	Xerlerate
FGM Training	Home Office
Forced Marriage E Learning	Home Office
Identifying and Responding to intrafamilial child sexual abuse	CSA Centre

7 minutes briefings by Telford and Wrekin Safeguarding Partnership

- Safeguarding Adults Reviews
- Alcohol and Substance Misuse During Pregnancy
- Professional Boundaries
- Sarahs Law
- Professional Curiosity
- Care Planning Briefing
- Roles & responsibilities
- Supporting International Students
- Information Sharing
- Trauma Informed Practice

7 minutes briefings by Telford and Wrekin Safeguarding Partnership

- Online Safety
- Contextual Safeguarding
- Domestic Abuse
- Predatory Marriage
- DHRs and Suspected Suicide
- Self Neglect
- Modern Day Slavery
- Home Takeover

1 What is the aim of a SAR?

The aim of a Safeguarding Adult Review (SAR) is to carry out a multi-agency review to determine whether the agencies involved in someone's life could have done things differently that could have prevented harm or death from taking place. The aim is not to apportion blame - it is to promote effective learning and improvement to prevent future deaths or harm occurring and to improve how agencies work together.

2 Why are SARs important?

SARs are an opportunity to look and learn and help understand what went on in that case and how it might help all services to get it right more of the time. It is vital that any SAR seeks to get the views of the person (if possible), their family and anyone else in the community who can help improve our understanding. They can also identify and share good practice too.

3 The Care Act 2014 (s.44) requires a SAR when:

- there is reasonable cause for concern about how the Safeguarding Adults Board (SAB) members or other agencies providing services, worked together to safeguard an adult; **and**
- the adult has died, and SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died); **or**
- the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect. The SAB has discretion to undertake a SAR in other situations where it believes that there will be value in doing so, for example in the public interest.

4 What if a case meets the criteria?

Professionals should complete the SAR Referral Form.
Shropshire: www.shropshiresafeguardingcommunitypartnership.co.uk/media/2erjcqly/sscp-safeguarding-adult-review-referral-form.pdf
T&W: www.telfordsafeguardingpartnership.org.uk/news/article/13/spotlight-on-safeguarding-adult-reviews-sars

The referral is reviewed by the SAR Panel against the criteria & a recommendation is made to the SAB as to whether a SAR should take place. The Independent Chair makes final decision and a SAR is commissioned. The referrer is then updated on the outcome.

Useful websites
Telford: www.telfordsafeguardingpartnership.org.uk
Shropshire: www.shropshiresafeguardingcommunitypartnership.co.uk

5 How are SARs carried out?

- Written by an external & independent reviewer with specialist skills and knowledge.
- Terms of reference for the SAR are recommended by the SAR Panel & agreed by the SAB Independent Chair.
- All agencies involved contribute by providing chronologies of their involvement & by taking part in a series of multi-agency meetings; the views & experiences of practitioners are sought.
- Draft report & action plan produced by reviewer and signed off by SAB.
- Anonymised SAR is published on the SAB website.

6 What happens if the case does not meet SAR criteria?

If a referral does not meet the s.44 criteria, another course of action may be agreed to ensure the learning is not lost; such as:

- A review primarily involving a case file audit, where this is reasonable and proportionate;
- A management review (within one or more organisations, i.e. a Single Agency Review, or Multi Agency Review) or;
- A discretionary SAR.

7 What difference do SARs make to safeguarding?

- SAR recommendations are used to agree an action plan for making changes or improvements to services in order to reduce the risk of future harm.
- Actions Plans are agreed and monitored to make improvements.
- Learning from the review is shared with partners on the SAB websites & through internal and external learning events.

Telford and Wrekin Safeguarding PARTNERSHIP

7 MINUTE BRIEFING

Safeguarding Adult Reviews (SARs)

Telford and Wrekin Safeguarding PARTNERSHIP

7 MINUTE BRIEFING

Sarah's Law Disclosure

1 What is Sarah's Law?

The Child Sex Offender Disclosure Scheme (CSODS) lets you formally ask the police whether someone who has contact with a child or children:

- has a record for child sexual (paedophile) offences
- poses a risk to the child or children for some other reason.

It's not a law, but it is sometimes called 'Sarah's Law' as it was developed by the Home Office, working together with the mother of Sarah Payne, to help safeguard children against child sex offenders. It gives guidance on how you can ask us to use our existing police powers to share information about sex offenders.

If you're worried about someone's behaviour towards a child, or something you've seen, heard or been told, you can use Sarah's Law to find out if that person is a risk.

You must apply for information about a specific person and a specific child or children they spend time with. You cannot apply for general information about child sex offenders.

2 Who can apply?

Anyone who is worried about someone's behaviour towards a child can apply, not just a child's parents. This includes people like a grandparent, neighbour or friend.

No matter who makes the application, if there is information that needs to be shared it will be shared with the person who is able to use the information to keep the child safe.

This might not be the person who made the application, it might be someone else (like the child's parents).

3 How can a member of the public make a disclosure request?

Contact the police via:

- applying online
- calling 101
- visiting your local police station

You will need to provide your contact details, the details of the person and child(ren) you are concerned about and why you are concerned.

4 What happens next?

After you apply for information under Sarah's Law the police will:

- make some checks within 24 hours and action will be taken straight away if they believe a child is in immediate danger
- decide if the request falls under Sarah's Law or not and make contact with you to explain this
- carry out detailed checks and a full assessment of all the information to
- decide whether there is any information to share with you or anyone else.

Are you worried about someone?
Don't sit in silence!

Please contact Family Connect on 01952 385385 or in an emergency call 999.

5 What we need our Partner Agencies to do?

Although there will be a wider communications campaign in the future we really need you to promote this with the members of public you come in contact with

This does not replace existing child protection arrangements and if partners have concerns then they should follow their own agencies procedures

1 DHRs – why they are important

When a person aged 16+ dies owing to violence, abuse or neglect by a partner, ex-partner or family/household member the Police make a referral for consideration of a DHR. This allows agencies to work together to learn lessons and make plans to improve support in the future. Please see the latest research. www.vkpp.org.uk/assets/Files/Domestic-Homicide-Project-Year-2-Report-December-2022.pdf

2 Domestic abuse and suicide

Research has shown that between 2020-2022 114 people died of suspected suicide in the backdrop of domestic abuse. That is five people a month.

81% of those who died were women and 19% men. DHR guidance states that when someone has died of suspected suicide in these circumstances then a DHR referral should also be made.

3 Risk Factors associated with suicide and Domestic Abuse (DA)

The research has looked at these deaths and identified the risks most associated with suicide when experiencing domestic abuse. These are

1 Perpetrator already known to Police for DA.
2 Coercive and controlling behaviours are used.
3 Perpetrator has problems with alcohol.
4 Non-fatal strangulation has been used.
5 Perpetrator misuses drugs.
6 Perpetrator has mental health problems.
7 Relationship ending increases risk.
8 Perpetrator has experienced depression/anxiety.
9 Perpetrator has previously been suicidal.
10 Perpetrator has also experienced DA.

www.vkpp.org.uk/vkpp-work/domestic-homicide-project

4 Coercive and controlling behaviour

Is a way of harming, punishing or frightening someone to make then give in and be dominated. This can be done through assaults or more subtle less obvious methods such as threats, humiliation or intimidation which is not as easily recognisable. It is an offence under Sect 76 of Serious Crime Act. It can include checking phone/spending/bank account; dictating access to friends/family or time on own; preventing access to see GP or professionals; threatening to expose them; threatening to harm the person or themselves, family/children or friends; denying access to interpreter or controlling who they can see or where they can go. It can have a devastating impact and people sometimes only realise the impact retrospectively.

5 Help and support

When aware that someone is experiencing DA consider all of the risk factors, have a conversation with the person in a safe space and consider the various services that are available and when you might need to refer to MARAC. Use the dedicated Domestic Abuse Pathway which explains how to respond to domestic abuse, where to get help and how to refer to MARAC in Shropshire and Telford.

www.shropshiresafeguardingcommunitypartnership.co.uk/media/oa2n0ein/sscp-domestic-abuse-pathway-a3-sep22-v4-pp-1.pdf

www.telford.gov.uk/info/20291/domestic_abuse

6 Things to think about

When a person experiences DA asking for help can be incredibly hard, not speaking up can be considered a logical way to prevent harm to themselves or others; so patience and understanding is a minimal requirement. Be professionally curious, be persistent but person centred.

Use flags on your organisations system to ensure risks are understood and explain what support is available. Always consider the risk of suicide as well as further violence.

7 Other risks

This briefing focuses on the risks associated with victim suicide in the presence of DA, but it is important to remember during the same period there were 202 homicides caused by (ex)partners and 103 adults died as a result of homicides by family members. Family homicides victims are 47% female and 53% male whereas partner homicide victims are 70% female. It is important to apply this information when working with those groups.

Telford and Wrekin Safeguarding PARTNERSHIP

7 MINUTE BRIEFING

Domestic Homicide Reviews (DHRs) and Suspected Victim Suicides

7 MINUTE BRIEFING

Predatory Marriage

1 Introduction

Predatory Marriage is the practice of intentionally targeting and marrying a vulnerable (often older) person in order to gain access to their estate and assets upon their death. Predatory Marriage relies on grooming and coercion to exert control over another person to persuade them to marry for financial, material or other gain.

2 Legislation

In UK law, marriage and civil partnerships rely on consent. The Marriage Act 1989 requires that two adult parties agree to a marriage, it is implicit that they understand and agree to marry by giving informed consent which is dependent on capacity to make decisions as determined by the Mental Capacity Act 2005.

The Anti-Social Behaviour, Crime and Policing Act 2014 created the criminal offence of forced marriage. It is a criminal offence to marry a person who lacks the mental capacity to consent to the marriage, regardless of any pressure. It is also a crime to pressure someone to marry by any means.

3 What Does Predatory Marriage Look Like?

Grooming: Predators may identify a vulnerable target and spend time "grooming" them to persuade them that they hold them in high esteem and to make them feel valued and loved. Predators often describe themselves as the victims carer. The predator may move into the home.

Isolation: Predators may spend time creating physical and emotional divisions between the individual and their friends and family to ensure only their voice is heard in isolation.

Harassment: Predators may stimulate or create conflict and division within families & friendship networks.

4 Signs, Indicators, and examples

The signs and indicators are similar to other types of abuse, the person may appear isolated, withdrawn, fearful or unsure about their relationship or the people around them.

When dementia is present, the victim may not be confused or fearful. Presenting as 'pleasantly confused' should not be interpreted as consenting

One example of predatory marriage is that of JB here who was targeted in Leeds by a younger man and covertly married in November 2015, this predatory marriage only came to light following her death in March 2016.

5 Things to consider

- The registrar should interview adults separately to ascertain capacity and consent, and stop any marriages where concerns are raised
- Legally in the UK a marriage will always revoke a Will so anyone who marries (or who re-marries) would need to make a new Will to be clear about their wishes upon death
- Once married, the predator is entitled to make decisions regarding funeral arrangements which may eclipse any decisions made with family members prior to the marriage taking place
- Predatory Marriage relies on coercive control and is a form of forced marriage
- Lasting Power of Attorney does not protect against a coercive predatory marriage.

6 What to do

- Raise concerns with the registrar
- Discuss the case with the Forced Marriage Unit
- Advise the family to seek specialist legal advice
- Consider applying for a Forced Marriage Protection Order
- Consider a 'caveat in expectation of marriage' via a specialist solicitor
- Concerns should be reported to the police and local authority.

7 Additional Resources

- Predatory marriage – Ann Craft Trust www.predatorymarriage.uk

Are you worried about someone?
Don't sit in silence!

Please contact Family Connect on 01952 385385 or in an emergency call 999.

Substance use in Pregnancy

Telford and Wrekin Safeguarding PARTNERSHIP

1. Alcohol - There is no known safe alcohol consumption level in pregnancy, so a conversation with a woman who is worried that she has drunk alcohol in early pregnancy can be challenging. Heavy/binge drinking in pregnancy is associated with an increased risk of prematurity and low birth weight and a range of physical, behavioural, and learning problems, collectively known as fetal alcohol spectrum disorders

2. Tobacco - Smoking during pregnancy is associated with a range of adverse outcomes for unborn children, including reduced fetal growth. It is also associated with an increased risk of miscarriage, prematurity, placental abruption, and sadly stillbirth. It is important to ensure an offer of a referral is made to all mums currently smoking or who have stopped in the previous couple of weeks to specialist smoking cessation services. Also, consider alternatives that are likely to be safer than cigarettes, such as nicotine replacement therapy, in conversations with mum so that she can make an informed decision.

3. Cannabis - The main psychoactive component of cannabis can easily cross the placenta and the safety of cannabis use during pregnancy is unknown. Due to this uncertainty it is important to encourage mums to avoid using cannabis altogether. You should try and establish how much cannabis is being used and consider options to encourage less use. For cases of heavy usage a referral to specialist drug and alcohol services where more intensive psychosocial interventions may be offered should be considered.

6. Who to contact for help?

Telford STaRS – supporting those affected by drugs and alcohol in Telford and Wrekin

Telford STaRS

Professional referral - Telford Stars

5. Managing substance use in pregnancy

It is important to develop and agree a management plan in collaboration with mum. It is useful to base this on a risk-benefit discussion alongside any relevant evidence. The plan should be different depending on the type and frequency of the substances being used and contain information on support services within Telford and Wrekin.

4. Useful conversation starters

- Ask permission—"Is it OK if I ask you some questions about substance use that can affect pregnancy?"
- Use third person—"Health professionals are encouraged to ask all women in pregnancy about substance use. Is it OK if we explore this?"
- Assess types and amounts of substances—"What are you taking? How do you use it and how often? Are you using anything else? How much are you spending?"
- "Is your partner or anybody else in the family also using substances?"
- "What is your understanding of the impact of the substance use on you and your baby during pregnancy?"
- "Are you booked with maternity services and receiving antenatal care?"
- "Have you been referred to any other services such as a specialist addictions service? What are those services currently providing?"
- "Who is supporting you during pregnancy and after birth?"
- "Would you like to breastfeed?"

Home Takeover (previously known as Cuckooing)

Telford and Wrekin Safeguarding PARTNERSHIP

1. What is it?

Home Takeover or Cuckooing is a crime that often, but not always, accompanies 'County Lines' offending and occurs when drug dealers take over the home of a vulnerable person to use for drug dealing and other criminal activity. The crime of 'cuckooing' vulnerable people is named after the cuckoo's practice of taking over other birds' nests for its young

2. Victims

Victims are often lonely and isolated. They can have drug or alcohol problems and sometimes be involved in criminality themselves. They may not present as 'typical' victims and often do not identify as such. They can be older adults, people with learning disabilities, mental or physical health problems, sex workers or single mums

3. How can it happen

Victims can be groomed, including via social media, and deceived into viewing the offenders as potential benefactors, friends or even romantic partners, before intimidation, physical or sexual violence and debt bondage –'re-paying' the cost of drugs first given as 'free' – are used as means for gaining control of the property

4. Legal impact

Under the Misuse of Drugs Act 1971, landlords or property managers can receive up to 14 years imprisonment or a substantial fine for having drugs residing at their property. The property may be seized or forfeited as well a prosecuted for money laundering. The premises may be 'closed down' and boarded up under the terms of a Premises Closure Order: (Section 76 Anti-Social Behaviour, Crime and Policing Act 2014)

5. Warning signs:

- An increase of vehicles and people stopping at the property, often for short periods at various times of the day or night
- An increase of anti-social behaviour / drug use around the property
- Not seeing the resident of the property as often

The individual may have:

- Stopped engaging with support services
- Present with unexplained injuries
- Paid off debts (including housing debts) in full and in cash
- Appear withdrawn and fearful of disclosing information for fear of 'betraying' the criminals, abuse or eviction
- Started associating with new unidentified people who are often present at the home
- Changed their appearance either wearing expensive clothing or appearing unkempt

6. What to do if you are concerned for someone

Are you worried about someone? Don't sit in silence! Please contact Family Connect on 01952 385385 or in an emergency call 999

Professional Boundaries

Karen Littleford, Partners in Care

Shropshire Safeguarding Community Partnership

Telford and Wrekin Safeguarding PARTNERSHIP

1. What are Professional Boundaries?

Boundaries are there to keep people safe. They are a set of guidelines, expectations and rules which set the ethical and technical standards in the social care environment and in related sectors. Professional boundaries set limits for safe, acceptable, and effective behaviour by workers (Cooper, 2012). They provide an outline of what is acceptable and unacceptable for a professional, whilst at work and outside of work.

2. Who Has Professional Boundaries?

Professional Boundaries apply to those who are working or volunteering in a role that could be described as being in a position of trust. This includes roles within social care, health, housing and other connected sectors including voluntary roles.

3. Why Do We Need Professional Boundaries?

Having professional boundaries ensures that the relationship between social care, health workers (and other workers or volunteers) and the children/adults they support remain professional, even when working with personal and difficult issues (Hardy, 2017). Upholding key boundaries not only protects workers, but also protects children/adults using specific services and the organisation (Hardy, 2017).

7. What To Do If You Are Concerned About Professional Boundaries?

- Talk to your line manager if you are concerned about your own boundaries or those of someone else you work with
- Ensure individuals using services, family members and others know how to raise concerns about boundaries with the service

4. Examples of Professional Boundaries Breaches (not exhaustive):

- Confidentiality breaches
- Sharing inappropriate information or photos of children/adults who use a service on social media
- Inappropriate physical contact
- Inappropriate language, or use of terms of endearment instead of the individuals name
- Using influence in a position of trust to gain
- Accepting gifts and hospitality outside of the organisational gift policy
- Inappropriate relationships with children/adults using a service
- Influencing the child's/adults' decisions or imposing views
- Stepping over the line and becoming a friend with the individual using the service rather than being friendly and approachable
- Oversharing of private or intimate information
- Not reporting incidents, concerns or safeguarding issues

6. How Can Organisations Manage Professional Boundaries?

- Ensure staff are aware of the Code of Conduct for their role
- Provide training and support so staff and volunteers understand their boundaries
- Embed clear policies and procedures
- Develop a culture where professional boundaries are discussed and addressed
- Recognise the relationship between professional boundaries and safeguarding

5. Consequences of Breaching Professional Boundaries

Relationships are an important part of our role in social care, health, housing and connected sectors. When staff or volunteers breach their boundaries, the impact may result in:

- Loss of trust or disillusionment
- Withdrawal from others and services that the child/adult requires
- Abuse or neglect
- Significant and enduring harm

References: Cooper, F. (2012) Professional Boundaries in Social Work and Social Care. London: Jessica Kingsley Publishers.

Hardy, R. (2017) Top tips on managing professional boundaries in social work. Community Care, June 19 2017. https://www.communitycare.co.uk/2017/06/19/top-tips-managing-professional-boundaries-social-work/

Supporting International Students

Telford and Wrekin Safeguarding PARTNERSHIP

Background

A recent CSPR completed, has identified the potential vulnerabilities our International Students in independent schools may have. These may require additional support planning and intervention from a range of agencies, taking a systemwide approach to meeting the child or young person's individual needs. It must be acknowledged, children and young people moving into the country, may have additional vulnerabilities, previous intervention in their country of origin and cultural needs that must be met by those working with them.

Time to reflect…

- What reasonable adjustments do you offer within your practice?
- When caring for an International Student, are you assured you have received all required information from previous teams to support your holistic assessment and care/treatment/education plan?
- Are you professionally curious in your practice?
- In your practice, who are you likely to share information with?
- How confident are you to share information in relation to a child or young person who is an international student?
- How confident are you to have a conversation with the family who may reside in another country? How would you arrange this?
- How could you enhance information sharing in your practice?
- Do your records clearly capture the review of records and decisions around the child/young person's care and needs?
- Are there barriers in your practice to fully support international students? If so, how do you overcome these?
- How do you ensure your have "closed the loop" and obtain feedback when required?

Key Documents & links

Best Practice Guidance for Supporting Health & Wellbeing of Children & Young People moving into UK from abroad for Education

Department for Education (DfE) (2023) Improving multi-agency information sharing (PDF). [London]: Department for Education

Department for Education (DfE) (2024) Information Sharing: Advice for practitioners providing safeguarding services for children, young people, parents and carers. [London]: Department for Education

Association for the Education & Guardianship OF International Students https://aegisuk.net/

How can we support our International Students?

- Be **culturally sensitive**; this may require reasonable adjustments being made ie: translation services, additional appointment times and offer an open culture that values diversity and inclusion.
- Provide a sense of **belonging**, support **integration** and **inclusivity**
- Upon **GP registration** (within 10 working days), ensure information and appropriate documents have been sought by the education provision/other agencies/providers in terms of needs identified by the parents/carers, child or professionals.
- If additional needs are identified, arrange a **face-to-face** appointment
- **Code** in the child/young person's records accordingly using SNOMED "international student" along with stating additional needs and/or safeguarding concerns.
- **Review documents** received and follow up any outstanding (ensuring they form part of the medical record), document parental responsibility and ensure any required referral to specialist care is completed
- **Medication prescribing and dispensing.** Any young person moving into the UK requiring medication previously prescribed out of country, must be reviewed and prescribed by the registered GP. The GP and Pharmacist should follow local protocol or formulary and seek review from specialist services ie: CAMHS, Community Paediatrician, Secondary Care and GP if required.
- If **safeguarding concerns** are suspected or identified, a referral should be made to the local MASH team and concerns documented in records. Always consider **Early Help** if additional support is required.
- Parents must appoint an **Education Guardian** for the child/young person who will act as a local point of contact and support for the child
- Where concerns exist regarding the health and wellbeing of the child/young person, if they **move within the UK** for temporary or longer-term residence; children's social care, the GP practice and school should work together ensure an **appropriate handover** to the local teams responsible, including the appropriate staff at the child/young person's residence.

Telford and Wrekin Safeguarding PARTNERSHIP

7 MINUTE BRIEFING

Domestic Abuse

1 What is a domestic abuse?

Domestic Abuse is any behaviour which is violent, controlling, coercive or threatening to those aged 16 or over. There are many forms abuse can take including, but not limited to, any behaviour which damages a person's confidence and sense of wellbeing, intimidation, threats around revenge porn, isolation from family and friends, control over a person's finances and appearance, threats made about a person's loved ones or direct physical abuse. The abuser may be a partner, ex-partner, family carer or one or more family members, in an existing or from a previous domestic relationship.

2 Why is domestic abuse a concern?

Nationally, an average of just over 100 women and 30 men are killed by a current or former intimate partner each year. 30 women a day attempt suicide, and each week, 3 of these attempts are successful. Domestic abuse is a crime and has more repeat victims than any other crime – we all have a duty to act and help prevent the hundreds of domestic abuse related suicides and murders.

3 Who is affected?

Research suggests that 1 in 4 women and 1 in 6 men will experience domestic abuse at some point in their lives. This means that during the course of your work you will encounter people who are experiencing domestic abuse. Remember, colleagues are not immune from Domestic Abuse either – any one of them may be experiencing domestic abuse of one form or another. Children in households where there is domestic abuse may carry the psychological scars for decades and where the behaviour is normalised, there may be a greater likelihood of them becoming perpetrators or victims in their teenage/adult life.

4 What to look out for

People affected by domestic abuse may exhibit one or more of the following signs:

- always checking in with their partner
- change in socialising and behaviours
- unexplained injuries
- financial worries
- become withdrawn, having low self-confidence and esteem
- changes in how they present themselves (clothes, hair, make up etc.)
- Repairs – have the Police asked for a lock change? Is there damage to internal walls and doors? (Especially bathroom/toilet doors)

5 What's my role?

If you work with the public, you are working with Domestic Abuse and doing nothing is not an option! Take the time to familiarise yourself with the information and training available to you.

Are you worried about someone? Don't sit in silence!

Please contact Family Connect on 01952 385385 or in an emergency call 999.

6 Resources

Clare's Law – this scheme gives any member of the public the right to ask the police if their partner may pose a risk to them. It is often called 'Clare's Law' after the landmark case that led to it.

www.westmercia.police.uk/advice/advice-and-information/daa/domestic-abuse/alpha2/request-information-under-clares-law/

www.familyconnecttelford.co.uk

7 What happens if I make a report?

Your local domestic abuse champion or Safeguarding lead may ask you for more information. Details will be shared with the Police and other agencies who will decide on how best to respond. The fact that you made the referral will not be shared with any of the parties involved.

Telford and Wrekin Safeguarding PARTNERSHIP

7 MINUTE BRIEFING

Self Neglect

1 What is a self neglect?

Self-neglect is included as a category under adult safeguarding in The Care Act (2014) Statutory Guidance. Self-neglect covers a wide range of behaviour such as neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. Local authorities have a duty to make enquiries, or cause others to do so, if it believes an adult is experiencing, or at risk of, abuse or neglect.

2 Signs of self neglect

Characteristics of self neglect can include:

- Lack of self-care to an extent that it threatens personal health, hygiene and safety
- Animal collecting with potential insanitary conditions and neglect of animal needs
- Failure to manage personal affairs such as social contact and finances
- Obsessive hoarding creating fire hazards.

3 Causes of self neglect

It is not always possible to establish the root cause however self-neglect can be a result of:

- Brain injury, dementia or other mental disorder
- Obsessive compulsive disorder or hoarding disorder
- Physical illness which has effect on abilities, energy levels, attention span, organisational skills or motivation
- Reduced motivation as a side effect of medication

People with mental health problems may display self-neglecting behaviours however there is often an assumption that self-neglecting behaviours indicate a mental health problem – this may not be the case.

4 How to help

Safeguarding duties apply where the adult has care and support needs that means they are unable to protect themselves against self-neglect.

In most cases, the intervention should seek to minimise the risk while respecting the individual choices. Research has shown that approaches such as 'deep cleans' can be deeply upsetting and not useful for the individual.

Are you worried about someone?
Don't sit in silence!

Please contact Family Connect on 01952 385385 or in an emergency call 999.

5 Good practice

- Work with partners to ensure the right approach for each individual
- Be person-centered to respect the views of the individual and work towards outcomes they want
- Be analytical to identify underlying causes that help address the issue
- Have patience and gain trust from the individual and agree small steps at a time

In terms of practical tasks, risk assessments have effective, multi-agency approaches to assessing and monitoring risk. Professionals should feel competent in applying the Mental Capacity Act in cases of self-neglect or in a minority of cases complete a Mental health assessment.

6 Questions to consider

How would you recognise the signs of self neglect and hoarding?

Have you read the Adult Self-Neglect Best Practice Guidance

Contextual Safeguarding

Telford and Wrekin Safeguarding PARTNERSHIP

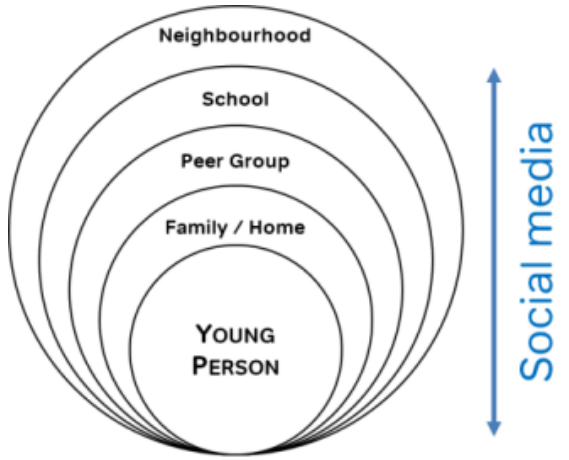
1. What is it?

Contextual safeguarding seeks to identify and respond to harm and abuse posed to young people outside of their home, either from adults or other young people.

2. Why does it matter?

Traditional approaches to protecting children and young people from harm have focussed on the risk of violence and abuse from inside the home, and do not always address the time that children and young people spend outside the home. As children move from childhood into adolescence they spend increasing amounts of time socialising independently of their families. Contextual safeguarding recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts and young people's experiences of extra-familial abuse can undermine parent-child relationships.

3. Expanding the capacity to safeguard:



6. Push Factors – some reasons that could lead to a young person becoming distant from the people who would usually protect them:

- Living with domestic abuse
- Being thrown out of home
- Family behaviours and beliefs
- Being in a residential or foster placement where they are unhappy
- Alcohol or substance misuse within the home
- Parents with mental health problems
- Having problems at, or not being in school, training or employment
- Being bullied or threatened
- Having siblings with difficulties
- Being in trouble
- Bereavement or significant loss

4. An approach, not a model:

- We need to recognise that children and young people are vulnerable to abuse beyond their front doors and via the internet/social media
- Target the context in which the abuse occurs, from assessment through to intervention.
- Frame work to address extra-familial risk through the lens of child welfare and not crime reduction or community safety
- Utilise the partnerships between agencies that reach into extra-familial contexts (transport providers, schools, retailers, resident associations, parks & recreational services etc.)
- Measure success with reference to the nature of the context in which the harm has been occurring, rather than focussing on any behaviour changes displayed by young people who were at risk of these contexts

5. Pull Factors - The grooming techniques used to gain the young person's attention, admiration, and affection often that often tap into their insecurities or desire for acceptance and status:

- Receiving alcohol, drugs, money, or gifts
- Getting a buzz and the excitement of doing something risky or forbidden
- Feeling accepted
- Being offered somewhere to stay where there are no rules
- Being given lifts, taken to new places and having adventures with a casual acquaintance
- Being part of an alternative scene
- Meeting somebody who thinks they are special on the internet/social media

Online Safety

Telford and Wrekin Safeguarding PARTNERSHIP

1. What is online safety?
Simply put, online safety refers to the act of staying safe online. Commonly known as internet safety, e-safety and cyber safety. It encompasses all technological devices which have access to the internet from PCs and laptops to smartphones and tablets.

2. Who can it affect?
Online safety is paramount in the world we live in, it can affect absolutely everyone from you personally to multinational companies. Ikea, Post Office and the NHS have all been affected . Lack of knowledge can make you especially vulnerable. There are ways which you can protect yourself by becoming aware of how you may be affected. 'STOP-THINK-FRAUD'

3. Why is online safety important?
There are different ways that you could be affected. Financial scams, fraudulent websites, online scams via Social media platforms such as Instagram, Text messages, phone calls, Courier fraud and even QR codes. Fraudsters use a range of ways to try and get your personal details for identify theft or financial gain. Companies can be targeted using Ransomware, enabling them to access data held by these companies. Phishing/smishing emails and texts target consumers pretending to be from a well-known source. Opening these confirm the number or email is live and make you vulnerable to further attacks. Quishing is when QR codes are stuck over legitimate ones for example parking charges.

4. What you can do.
•**DO**: Choose Strong Passwords. Password managers can help. Do not use identifiable information such as dates of birth, children's names etc. Don't use the same password. Three random words, make them complex add characters for letters for numbers.
•**DON'T** share your password.
•**DO**: Enable Two-Factor Authentication. Makes it more secure if using different devices.
•**DO**: Keep your devices and apps up-to-date, for up-to-date software and security
•**DON'T** stick with a Single Email Account. Create a separate email account for important things such as banking.
•**DON'T** store Personal Card Details on Websites.

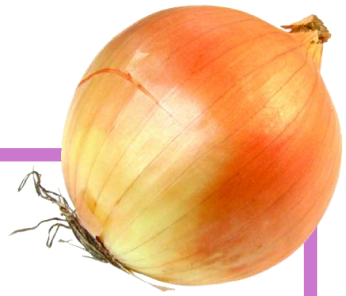
5. Consequences.
Fraudsters can obtain personal details, bank account details, potential passwords for other sites, safeguarding information and most of all money. The amount of money lost to fraud in a single month during 2024 in our local area is £1.5 million, nationally this figure rises to £105 million. Scammers are very good at finding vulnerabilities particularly around love and belonging. Repeat victims often are aware they are being scammed they will continue contact and sending money, as they feel it's their only form of human contact.

6. What to do if concerned.
Happening now call 999.
Further information is available online to support you. The Little Guide to... preventing fraud and cyber crime | Metropolitan Police
You can request a check to see if your data has been part of a breach. Here. This will prompt you to change passwords on relevant sites.
Check if a financial firm is authorised Here.
The key message is **'If it looks too good to be true it probably is'**

7. Help available.
Action Fraud – report fraud and cybercrime. www.actionfraud.police.uk or call - 0300 123 2040
Phishing emails report to – report@phishing.gov.uk
Text (Smishing) fraud – text to 7726
Report a Fraudulent website – ncsc.gov.uk/report-scam-website
Financial conduct Authority - https://www.fca.org.uk/

Telford and Wrekin Safeguarding PARTNERSHIP

Trauma Informed Practice



The young people's voice along with that of parents and carers through Telford and Wrekin Consultation

Question: "How should we work alongside trauma?"

"Be trauma attuned" "understand the impact trauma has and the layered impact"

"how is it understood in the context of the person and the family",

"see beyond the layers and how trauma can impact on relationships within the family, with practitioners and how we foster growth and recovery".

Young people tell us they want adults Supporting them to:

- Know that everyone's experience is different, and it doesn't define who I am
- Recognise all of my needs and see me as a whole person
- Understand my behaviour – when I'm shouting, crying, hiding, stealing, hitting out at myself or others, I'm just trying to make sense of everything I've gone through
- Find a way to communicate that works for me
- Include me in decisions about my life – ask me what I want to happen
- Build on my strength and help me find new ways to recover

Trauma and Mental Health | Guide For Parents | YoungMinds

Accessing support for children and young people, parents & carers and professionals working with families:

- Speak to school
- Speak to the General Practitioner
- Emotional support services

BeeU :: Midlands Partnership University NHS Foundation Trust (mpft.nhs.uk)

"Trauma is an invisible force that shapes our lives. It is the way we live, the way we love and the way we make sense of the world. It is the root of our deepest wounds"

"Trauma is not what happened to you, but what happens inside you as a result of what happened to you"

DR GABOR MATE

Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development" (Office for Health Improvement & Disparities, 2022)

Trauma results from an event, series of events or set of circumstances that is experienced by an individual as harmful or life threatening which can cause lasting adverse effects. As a professional, we must consider the 6 key principles of trauma-informed practice:

- **Safety** – ensuring the physical, psychological, and emotional safety is prioritised
- **Trust** –transparency existing among staff, children and young people, wider community and organisational policy and procedures
- **Choice** – supporting children and young people in shared decision making, choices and goal setting
- **Collaboration** – recognising the value of children/young people and professionals working with families in overcoming challenges and improving systems
- **Empowerment** – giving children, young people and professionals working with families a voice in decision making
- **Cultural consideration** – moving past cultural stereotypes and biases based on individual beliefs, cultures, and characteristics.

Professional Curiosity

Telford and Wrekin Safeguarding PARTNERSHIP

1. What is professional curiosity?

"Professional Curiosity is a combination if looking, listening, asking direct questions, and reflecting on information received". (Quote: Worcestershire Childrens Safeguarding Board). It is a golden thread through all Safeguarding Partnership learning reviews and audits and is an essential part of safeguarding. Nurturing professional curiosity is a fundamental aspect of working together to keep children, young people and adults safe. A lack of professional curiosity can lead to missed opportunities to identify less obvious indicators of vulnerability/significant harm.

2. Why it matters?

Incorrect assumptions can be made in assessments of needs and risk which could lead to wrong interventions for individuals and families. It is natural to want to believe the best of a family, thinking the unthinkable does not mean assuming the worst. It means keeping an open mind, thinking objectively about the evidence presented. Professional curiosity involves using more than one source of information, using appropriate language, tools, and settings. Information sharing comes up as an issue in 98% of statutory case reviews!

3. Use your senses!

- Look: Is there anything about what you see when you meet with this adult/ family which prompts questions/makes you feel uneasy?
- Looking beyond prejudice
- Are you observing any behaviour which is indicative of abuse or neglect?
- Does what you see support or contradict what you're being told?
- Listen: Are you being told anything which needs further clarification?
- Are you concerned about what you hear family members say to each other?
- Is someone in this family trying to tell you something but is finding it difficult to express themselves?

4. What to ask

- Ask: Are there direct questions you could ask when you meet this adult/family which will provide more information about the vulnerability of individual family members. Here are some examples:

- How do you spend a typical day? Who do you live with? When were you last happy? What do you look forward to? How did you get that injury? Who is this with you? When do you feel safe?

- Check out: Are other professionals involved? Have other professionals seen the same as you? Are professionals being told the same or different things? Are others concerned? If so, what action has been taken and by whom?

5. Think family

A Think Family approach to safeguarding work with children and adults and their families is essential. When completing assessments we need to take opportunities to see, feel and recognise risk and enquire deeper. Being open minded and curious will help to make an informed decision about the child's, adult's or families' lived experiences. Analyse all available information and record all concerns and considerations.

6. Be self aware in your practice

Professionals need to have a degree of caution in their judgements and triangulate information. This means seeking independent confirmation of individuals' accounts and weighing up details from a range of sources or practitioners, particularly when there appear to be discrepancies. Professionals need to be aware of their own values without letting them influence their decision making and practice in a way that is non-judgemental and anti-discriminatory. People can be convincing and it's really easy to take them at face value.

7. Top tips

- Be watchful for disguised compliance
- Using motivation interviewing techniques
- Appreciate the impact of lived experiences on someone's ability to be open and honest
- Think outside of the box
- Actively listen
- Use all of your senses (sight/hearing/smell/touch)
- Think the unthinkable

Modern Day Slavery

Telford and Wrekin Safeguarding PARTNERSHIP

1. The Modern Day Slavery Act 2025

The simple definition is the *movement or recruitment by deception or coercion for the purpose of exploitation.* The Act outlines in Section 1 the criminal offence of slavery, servitude and forced or compulsory labour and Section 2 covers the separate criminal offence of human trafficking.

The Anti-Slavery Commissioner role was created under the act and provision for the protection of victims also forms part of the act. This means that those victims who have been compelled to commit certain crimes, typically cannabis cultivation, begging, shoplifting and immigration offences may not be prosecuted.

2. Myths

Modern Slavery should not be confused with illegal immigration or people smuggling. It doesn't have to be cross border, it can be as simple as moving someone from one room to another. Individuals may have consented to travel, and this does not mean they aren't a victim, as often they have only agreed under false pretences. Victims are often trafficked from outside of the UK but it can happen to British citizens too. It's simply not true to say if someone hasn't attempted an escape, this does not mean they aren't a victim.

3. The Triggers

- **Economic** – victims may come from a background of poverty, unemployment, lack of opportunity and debt bondage. Many are driven to earn a better living abroad.
- **Social** – vulnerabilities may include homelessness, being uneducated, disabilities or learning difficulties, in the social care system, lack of family support or having a weak social network.
- **Political** – those who can be easy to exploit come from war, civil upheaval and social unrest. Many come to the UK for a better life.
- **Legal** – they may be fleeing from a weak judicial system, hold illegal documents or none at all and have little faith in the legal system or law enforcement agencies

4. The Signs

- **Anxiety** - Is the person you're speaking to visibly anxious? Are they hesitant to speak or slow to respond to questions? Are they showing signs of trauma or confusion?
- **Manner** - Do they have poor eye contact or seem withdrawn? Are they revealing feelings of worthlessness or hopelessness? Do they distrust authority figures?
- **Condition** – Do they look malnourished, exhausted or unkempt? Have they any untreated or neglected wounds? Are they poorly dressed or equipped for the job they are carrying out?
- **Environment** – Are they living in dirty or cramped accommodation? Rarely allowed to travel alone?

These are all signs that could suggest someone is subject to modern slavery.

5. Types of Exploitation and Human Trafficking

An individual may experience multiple forms of exploitation or abuse. The most common forms of exploitation include:

- Sexual exploitation (sexual abuse, forced prostitution and forms of child sexual exploitation).
- Labour exploitation (forced to work long hours for little or no pay).
- Forced criminality (compelled to commit crimes to benefit other persons).
- Domestic servitude (victims live and work in their 'employer's' household and are forced to work long hours)
- Organ harvesting (the surgical removal of parts of the body, sold for huge profits)

6. How to help victims

Victims may be reluctant and feel humiliated. They may be fearful of the police and threats may have been made against them and their families. You should always be patient and non-judgemental. Listen attentively and show empathy. Be professional, explain the reasons for your actions and reassure them that you are there to help.

Are you worried about someone?
Don't sit in silence!

Please contact Family Connect on 01952 385385 or in an emergency call 999.

7. Useful websites

Support for victims and their families - Telford & Wrekin Council

National referral mechanism guidance: adult (England and Wales) - GOV.UK (www.gov.uk)

Learning Briefing
Care Planning Meetings

Telford and Wrekin Safeguarding PARTNERSHIP

1. Purpose of a care planning meeting

Care Planning Meetings are held for children who are subject to local authority care. The purpose of a care planning meeting is to bring together professionals and significant people involved in the child's life to enable a collective supported response to meeting their needs in the best interest of the child/young person and promoting wellbeing. It provides an opportunity to make any changes to their care and support plan and agree clear actions and next steps incorporating any new risks identified and/or assessments completed. It is imperative to champion the strengths of the child/young person.

2. Frequency of care planning meetings

Care planning meetings take place as a minimum of every 4-6 weeks in line with the child's present circumstances however a care planning meeting should be arranged if there is anything of significance that has occurred in the child's life. Examples of this may include; missing episodes, instability of their caring arrangements ie: change of residence, identification or escalation of risk, change in the child/young person's needs and little progress or drift on agreed actions.

3. Membership of care planning meetings

Membership should include all relevant professionals and significant people involved in the child/young person's life. This includes but is not limited to:

- Children's Social Care and/or identified lead practitioner
- Specialist services (including CATE practitioners)
- Education provision (including alternative provision/virtual schools)
- Health professionals (including 0-19 service practitioner, mental health practitioners, private health providers ie: therapists)
- Birth parents
- Caregivers (including residential managers)
- Child/young person (if appropriate) or their advocate

If there are concerns in relation to attendance, this should be raised with the appropriate management teams by the lead professional.
The Independent Review Officer should be advised of the outcome and receive a copy of the minutes.

4. Roles and Responsibilities

It is the responsibility of all in attendance to contribute towards the discussion, share information, risk assessment and agree and formulate the child/young person's plan. Discussions and actions must include detail of the lived experience, voice of the child and impact on the child. Actions should be progressed with achievable timescales and must be reviewed with updates and evidence provided to the members at the following meeting.
Information shared is to include any privately commissioned assessments or work undertaken that inform the care planning of the child/young person. Any safety plans must be shared to inform the overall assessment and identified actions.
Accurate minutes must be a true reflection of the meeting that took place and any discrepancies to be raised with the minute taker for amendments where required.
There must be consideration for information to be written to the child/young person where appropriate.
If there are professional disputes, the partnership escalation policy must be followed.

5. Next Steps

A robust action plan must be agreed with clear timeframes set and accountable leads identified in the best interest of the child/interest; promoting their health and wellbeing.

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The plan should be clear around the impact on the child/young person's lived experience, capturing their voice and views.

The care plan must be a true reflection of their current circumstances and support in place.

Actions must ensure relationships when in the best interest of the child/young person, are promoted.

Any gaps identified must be addressed with a clear action.

6. Importance of information sharing

Information sharing is imperative in all safeguarding practice. Members attending the meeting hold the responsibility to share information back to their own agencies to inform further care planning in addition to bringing the required information to the meeting. Information shared should be proportionate and balanced.

Risk management and safety plans including updated plans must be shared within the meeting attendees following the meeting alongside the minutes. These should be shared within 10 working days.

7. Escalation

All attendees have the responsibility to escalate any cause for concerns in relation to attendance, progression of actions, professional drift, disguised compliance and/or additional safeguarding risks.

There must be clear lines of reporting for those attending the meeting should disputes be raised and where required using the Escalation Policy.

Please note, anyone (including family members) can request a care planning meeting.

Multi-agency working and information sharing

Telford and Wrekin Safeguarding PARTNERSHIP

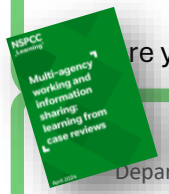
Background

Multi-agency working and information sharing are key to effective safeguarding and child protection (DfE, 2023). Information sharing is essential for identifying patterns of behaviour, or circumstances in a child's life that may be evidence that they are at risk of harm or being harmed and need some form of support or protection. As stipulated in DfE (2024), data protection legislation (Data Protection Act, 2018) and the UK General Data Protection Regulation (GDPR) **does not** prevent the sharing of information for the purpose of safeguarding children, when it is necessary, proportionate and justified to do so.

Time to reflect...

- In your practice, who are you likely to share information with?
- How confident are you to share information in relation to a child or young person?
- How confident are you to have a conversation with the family to advise them you are sharing information (if deemed safe to do so)?
- How could you enhance information sharing in your practice?
- Do your records clearly capture decisions around information sharing?
- Are there barriers in your practice to share information? If so, how do you overcome these?
- How do you ensure your have "closed the loop" and obtain feedback when required?
- Do you know who to contact within your organisation if you were unsure whether to share information?
- re you aware of the benefits of sharing information to safeguard children and young people?

Key Documents



Department for Education (DfE) (2023) Improving multi-agency information sharing (PDF). [London]: Department for Education

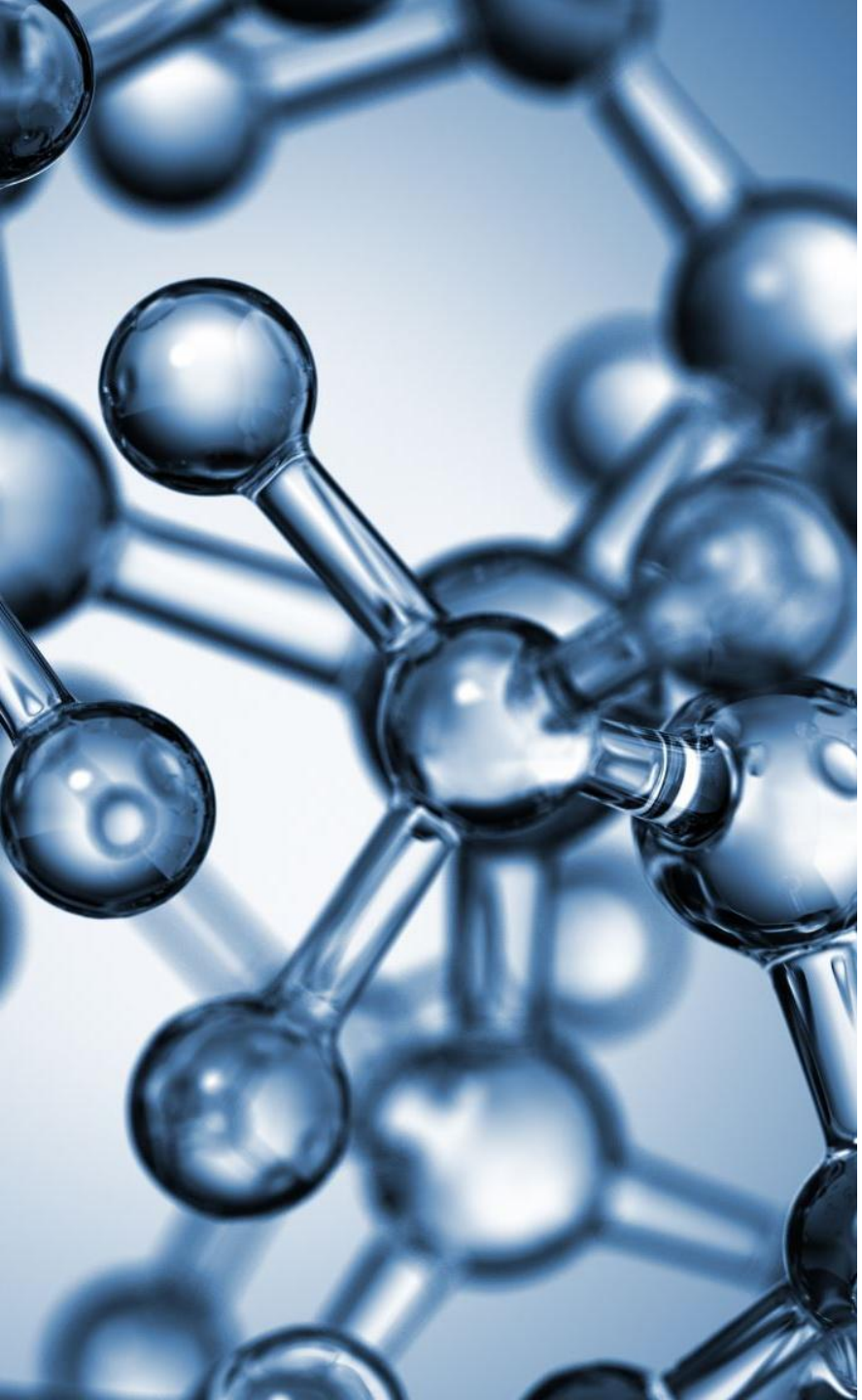
DfE non statutory information sharing advice for practitioners providing safeguarding services for children, young people,parents and carers

Department for Education (DfE) (2024) Information Sharing: Advice for practitioners providing safeguarding services for children, young people, parents and carers. [London]: Department for Education

Child Safeguarding Practice Review Panel (2024) Annual report 2022/23: patterns in practice, key messages and 2023/24 work programme (PDF). [London]: Child Safeguarding Practice Review Panel

7 Golden Rules (DfE, 2024)

1. All children have a right to be protected from abuse and neglect. Protecting a child from such harm takes priority over protecting their privacy, or the privacy rights of the person(s) failing to protect them.
2. When you have a safeguarding concern, wherever it is practicable and safe to do so, engage with the child2and/or their carer(s), and explain who you intend to share information with, what information you will be sharing and why.
3. You do not need consent to share personal information about a child and/or members of their family if a child is at risk or there is a perceived risk of harm.
4. Seek advice promptly whenever you are uncertain or do not fully understand how the legal framework supports information sharing in a particular case.
5. When sharing information, ensure you and the person or agency/organisation that receives the information take steps to protect the identities of any individuals (e.g., the child, a carer, a neighbour, or a colleague) who might suffer harm if their details became known to an abuser or one of their associates.
6. Only share relevant and accurate information with individuals or agencies/organisations that have a role in safeguarding the child and/or providing their family with support, and only share the information they need to support the provision of their services.
7. Record the reasons for your information sharing decision, irrespective of whether or not you decide to share information.



Learning from CSPRs / Rapid Reviews

CSPR 9	CSPR 10	CSPR 14 & 15 (Neglect thematic review)
CSPR 17	CSPR 18	CSPR 25

CSPR 9 – Learning Briefing

Background – A CSPR was undertaken for an 8-year-old child who lived with their mother and two siblings in the Telford & Wrekin Council area. The child had significant additional needs. In late December 2020, the child was hospitalised after being found unresponsive in their home address. The following day concerns arose that bruising on their body indicated that they had sustained non-accidental injuries. Child J, then aged 16 and normally a resident outside of Telford, was temporarily staying in the same address as the child, due to both children's parents cohabiting. Child J is a young person with complex needs, who, at that time, presented risks to themself and others. West Mercia Police later arrested child J on suspicion of the attempted murder of the child, who subsequently made a full recovery. After considering the evidence gathered by West Mercia Police, the Crown Prosecution Service decided that there was insufficient evidence upon which the case could be advanced further.

Positive and Proactive Steps

- The Telford and Wrekin Children Safeguarding Partnership have hosted a Trauma Informed Practice session which highlighted the need to 'Ask Why' and to look beyond the obvious.
- This session was further supported by the creation and dissemination of Contextual Safeguarding, Practice Guide, Professional Curiosity 7 minute briefings
- Within Family Connect, address checks are part of standard operational practice when the address is not already known for a family. Should it be identified that a family resides out of Telford & Wrekin, a referral is completed to a relevant Local Authority.

Process

Following receipt of the referral in January 2021 a Rapid Review was held where the panel agreed that the threshold for a joint Child Safeguarding Practice Review with the other local authority had been met. Immediate safeguarding actions were completed, and an independent author was sourced to undertake a joint review with both Local Authority Partnerships, with the review formally commencing in Spring 2022 with practitioners involved with the case, alongside managers from across the partnership and input from the families.

Recommendations and Learning – The learning identified in this review had three strands, learning applicable to both authorities individually, and together. The recommendation applicable to Telford and Wrekin are detailed below:

- To seek assurance from Telford and Wrekin Children's Services that the Family Connect Customer Relationship Team always undertake necessary address checks in respect of referrals and notifications received.
- To ensure professionals are aware to look beyond the obvious or dominant risk(s) and consider risk more holistically.
- To advise all relevant partner agencies that when an agency become aware that a person who has been assessed as presenting a risk to him/herself and/or others is known to be staying in a different geographic location, the 'home' agency or agencies should be responsible for considering whether to conduct an assessment of any risks which may arise from the person's presence in the different geographic area.
- To highlight the need to exploit any opportunity to gather information about a person who is visiting from a different geographic area and who may present risks to self and/or others.
- To explore the wider completion of hospital passports for children with complex additional needs with relevant partner agencies.

CSPR 10 – learning briefing

Telford and Wrekin Safeguarding PARTNERSHIP

Background

This case reviewed focused on a 4 month old baby who was born during pandemic and who came to significant harm whilst in the care of their parents, suffering non accidental injuries including fractures to their ribs, arm and femur along with bruising and swelling. Both parents were first time parents and were suffering from anxiety and depression which they had sought help for. One of the baby's parents admitted to causing harm intentionally.

Positive and Proactive Steps

- The Telford and Wrekin Safeguarding Partnership (TWSP) have ensured that professionals are reminded of the 'those who don't cruise rarely bruise' message along with circulation of the babies cry, you can cope resources for parents.
- Partner agencies have made changes to systems to fully engage with fathers (where they are known) and to 'Think Family'. Telford and Wrekin has also implemented a Family Safeguarding Model which is a multi-disciplinary approach to working with families.
- The TWSP have undertaken work to improve practitioners familiarity of current policies and national guidelines on bruising in non-mobile infants.
- Agencies are now more flexible in the way they engage with families to ensure intervention is relevant to the needs of the individual
- Revised Threshold of Need guidance has been circulated to practitioners along with accompanying workshops to allow upskilling and confidence in applying thresholds consistently.

Process

Following receipt of the referral in Spring 2021 a Rapid Review was held where the panel agreed that the threshold for a local Child Safeguarding Practice Review had been met. Immediate safeguarding actions were implemented and an independent author was sourced with the review formally commencing in June 2022 involving practitioners involved with the case alongside managers from across the partnership and input from the family.

Recommendations and Learning - Following completion of the report the following additional recommendations were made:

- That all efforts are undertaken to ensure that fathers/partners are fully known and engaged in their unborn/newborn baby's lives
- That fathers/partners are engaged and offered support and parenting intervention, particularly during the perinatal period
- Adult mental health services should work with Children's Services to ensure information shared reflects the family's situation, any support needs and impact on parenting and children
- Consideration of the family's situation and confidence in engaging online or in-person therapies should inform the agreed intervention
- In-line with the National Panel's guidance, the partnership review its current policies on bruising in non-mobile infants, to check for consistency with the evidence base and national guidelines. This needs to be clearly communicated to practitioners

CSPR 14 and 15 – learning briefing

Telford and Wrekin Safeguarding PARTNERSHIP

Case Background

CSPR 14 involved the death of a four-week-old baby. There do not appear to be any suspicious circumstances regarding this child's death. Following the death, significant concerns were identified about the living conditions of the baby and their siblings, who were living in the family home with their mother as their sole carer. CSPR 15 also involved concerns about home conditions. The family consisted of three children, one at primary school and two at secondary school. They lived with their mother and had regular contact with their father.

Positive and Proactive Steps

- Learning has taken place with all designated Safeguarding Leads in schools to consider ways to ensure they understand a child and their family's history in the context of their decision making around safeguarding concerns.
- The partnership actively encourages a 'think family' approach to ensure that professionals consider the wider family circumstances and background throughout any reviews, assessments or support. The Telford and Wrekin Family Safeguarding Model ensures that professionals are brought together to support parents to make positive changes. Encouraging professionals to be professionally curious is a regular theme within the various training session and training material.
- The Partnership has commissioned an independent reviewer to explore how we approach the issue of neglect. They are exploring how we work with families from the point of referral all the way through to Child Protection conferences. Engagement has already taken place across all partners at all levels to ensure . There has been key participation from families with lived experience which has allowed a crucial insight into how the words used by professionals and changes to documents would have aided the safeguarding process from their perspective. The new strategy is due to be in place by Spring 2024

Process

Following receipt of the referral relating to CSPR 14 in November 2022 a Rapid Review was held where the panel agreed that the threshold for a full Child Safeguarding Practice Review had been met. Shortly after this decision was made, a further referral was received in February 2023 relating to CSPR 15. Immediate safeguarding actions were implemented and an independent author was sourced to undertake a thematic review into neglect which commenced in April 2023 involving practitioners involved with the cases alongside managers from across the partnership and input from the families.

Recommendations and Learning – Following completion of the review in the following recommendation were made:

- The Partnerships recognises the need for, and implements, a neglect strategy and toolkit to improve the understanding of neglect
- barriers to engagement are explored to ensure that these are addressed across all partner agencies.
- Learning is shared regionally and requests are made that multiagency guidance on the management of concealed pregnancy be developed implemented.
- The Partnership seeks assurance that all schools are aware of the need and importance to access information about a child's history when they have any concerns
- Professionals are aware of the expectation to include all background information/concerns when making a referral

CSPR 17 – learning briefing

Background:

This case review focussed on the death of a young person following suicide. In the months before her death she had disclosed that she had been a victim of abuse which was being investigated by police. She had suffered with a history of self harm and overdoses which had led to hospitalisation. She had also been electively home educated prior to her starting secondary school during the Covid pandemic. A social work assessment had been undertaken and support to help her manage her feelings was offered which was subsequently reviewed as risks increased but support levels did not increase.

Positive and Proactive Steps Already Taken:

- The Telford and Wrekin Safeguarding Partnership (TWSP) will shortly been announcing the date of a partnership wide Trauma Informed Practice training session
- All practitioners have been reminded of the need to always remain professionally curious with the circulation of a 7 minute briefing
- The Escalation Policy has been reviewed and recirculated to all practitioners

Remaining actions will be completed by the end of the year

Process:

Following receipt of the referral in Spring 2022 a Rapid Review was held where the panel agreed that the threshold for a local Child Safeguarding Practice Review had been met. Immediate safeguarding actions were implemented and an independent author was sourced with the review formally commencing in June 2022 involving practitioners involved with the case alongside managers from across the partnership and input from the family.

Recommendations and Learning: Following completion of the report the following additional recommendations were made:

- reinforce the importance of all assessments being informed by a child's trauma and the importance of considering the parents' capacity to meet the child's needs is fully explored
- reinforce the need for professional curiosity and looking for reasons behind behaviours
- review arrangements for undertaking early help assessments and plans to ensure that when children have emerging needs, a co-ordinated early help response is offered and led by a Lead Professional.
- review escalation policy to ensure staff members understand the importance of escalating concerns about a partner agency to resolve the issue for the child and their family.
- seek assurance that the arrangements for monitoring home education take into account the child's holistic safeguarding and welfare needs
- seek assurance that the arrangements for investigating allegations of familial abuse outside of daytime services working hours are conducted in accordance with statutory guidance

CSPR 18 – learning briefing

Background
This case review considered a family of four children. The family were previously known to partner agencies in both Telford and Wrekin and another Local Authority due to child safeguarding concerns. The older children had been the subject of child protection planning and spent time in care due to significant neglect, largely due to parental drug misuse, mental health, and criminality. They had lived with their grandparents for eight years before returning to mum in 2018. A third child had been born in 2017 to mother and her partner and was initially on a child protection plan and then a child in need plan in Telford and Wrekin before the family moving away in 2018. Child 4 was born in April 2021 and sadly died a year later.

Positive and Proactive Steps

- The Telford and Wrekin Safeguarding Partnership (TWSP) have developed some practical guidance around being culturally aware.
- All practitioners have need reminded of the need to remain professionally curious via the 7 minute briefing and regular references in other training in order to understand the dynamics in the family and identify young carers
- Further awareness raising has taken place with wider partners, including Fire and Rescue to encourage them to highlight concerning home conditions they may see during routine visits with the local authority. The Home Conditions Procedure and assessment tool guides practitioners through various indicators and allows consistent scoring of risk to take place.
- The Hoarding and Clutter Rating Assessment has also be circulated to practitioners

Process

Following receipt of the referral in Spring 2022 a Rapid Review was held where the panel agreed that the threshold for a local Child Safeguarding Practice Review had been met. Immediate safeguarding actions were implemented and an independent author was sourced with the review formally commencing in September 2022 involving practitioners involved with the case alongside managers from across the partnership and input from the family.

Recommendations and Learning - As a thematic CSPR (neglect) was completed just prior to this incident, it was agreed that this review would consider the potential impact of the learning and to agree any further recommendations that may be required which are highlighted below:

- Remind professionals of the need to: * Be culturally aware and competent in assessments and direct practice. * Be sensitively honest about any difficulties in understanding a parent when English is not their first language. * Identify and support young carers. *Consider the needs and vulnerabilities of **all** members of the family. * Include unannounced visits in plans when working with a family where neglect and household conditions are a concern.
- That the Partnership considers how it can ensure improved and good practice regarding safeguarding children who move across local authority borders, including those who are children in need.

Learning Briefing CSPR 25

Telford and Wrekin Safeguarding PARTNERSHIP

Background:

This briefing is in connection to an international student, who was studying A-levels in England in 2023. Although initially described as shy and socially anxious, they gradually integrated, forming friendships and gaining confidence. Although the young person was articulate and was able to seek help when needed, it was documented that they often felt isolated and pressured to succeed. They experienced poor mental health, leading to anxiety and depression.

The young person died by suicide at the age 16 whilst attending a private summer residential programme at a university campus out of their primary education area. Their story reveals that being away from home and family can add to vulnerabilities such as mental illness and special educational needs. UK legislation emphasises family care for children, so that trusted adults can mitigate this vulnerability, as recognised in Keeping Children Safe in Education (2023). The education of international students is notable in schools and universities, with over 600,000 students coming to the UK annually. Therefore, the Review highlights significant gaps in regulation in safeguarding care for international students. Key themes, recommendations for safeguarding systems, and practice considerations for those working with international students in the UK is summarised below.

Themes 1: Reflection on Practice

Practice consideration A: That practitioners are reminded to be curious as to the everyday experience of students who are impacted by symptoms of as result of treatment and/or consider if the child's experience could be improved upon.
Practice consideration B: Practitioners should come together regularly to make sense of the lived experience of any students with additional needs.
Practice consideration C: That self-harming behaviour is never normalised or accepted by adults, but should be considered as a behaviour which suggests that a student is “dealing with very difficult feelings, painful memories or overwhelming situations and experiences.”

Theme 2: The response to an international student's, mental health

Practice consideration D: Due to potential culture differences regarding definitions of mental health and how diagnoses, symptoms, and possible labels are understood, there should be simple description of what information is requested and why it should be used.

System Recommendation 1 – For all boarding schools: where a student has a mental health diagnoses/treatment plan, the school should invite any mental health lead in the school and or clinical staff to attend alongside the school senior leadership team some or part of any admissions meetings with parents. The intended outcome is that the school can plan for any additional support the student might need, prior to the student arrival at school.
System Recommendation 2 – For all Integrated Care Boards (ICB): all children boarding with an independent school should be registered with a general practice local to the school premises. They should be assured that GP’s are clear regarding their role with international students. Any agreement between the GP and any independent day or boarding school in the locality should be supported by the local ICS/ICB in terms of quality and monitoring so that physical and mental health needs of this specific cohort are met.
System Recommendation 3 – For all Boarding Schools: Boarding Schools make prospective parents aware that students will be registered with the local GP. NB this may require a revision of the National Minimum Standard for Boarding Schools.
System Recommendation 4 - For all Boarding Schools: All students who arrive with known symptoms and a diagnosis of depression, mental health condition, or medical need, should be assessed and treated under the supervision of a UK-based clinician, with a regularly monitored treatment plan. The student’s health and wellbeing should be regularly reviewed by the multi-agency network of practitioners. Where consent is not given by the child a multi-agency meeting should be convened. The ISI and/or Ofsted should make their inspection of any school.
System Recommendation 5 – For all independent day and boarding schools employing school nurses. To ensure school nursing staff receive clinical and/or safeguarding supervision from a trained and accredited supervisor. This should be included in the ISI and/or Ofsted inspection frameworks.

Theme 3: Information Sharing and Seeking

System Recommendation 6 - For all boarding schools: That all adults involved in the care of an international student with additional needs are included in regular multi-disciplinary communications and meetings to reflect on the child's progress.

System Recommendation 7 - For all independent day and boarding schools: It is recommended that all independent schools be reminded of the DfE non-statutory information-sharing advice (May 2024) and its relevance to safeguarding practice.

Practice consideration E: It is important that the due diligence by boarding schools of the implementation of NMS 22 [regarding education guardianships] includes the assessment of both the quality and the consistency of homestays.

Practice consideration F: Practitioners should reflect on when to share information, using the new guidance, to promote a student's welfare and protect them from safeguarding risks, especially when the risk outweighs the individual's unwillingness to engage.

Theme 4: Working across agencies to respond to risk

System Recommendation 8 - For all boarding schools: Multidisciplinary meetings should be held when a student with mental health needs joins the school including a range of staff from within the school, as well as external agencies and parents. A multidisciplinary risk assessment and safety plan should be drawn up with the student and parents and implemented. Such a meeting will be dependent on the complexity and severity of the student's mental health needs.

Practice consideration G: Parents of international students can be helped, challenged, and supported to understand the options for their child's education and well-being. Schools should take the lead so that teachers and staff can implement their duty of care for the child.

System consideration - For all boarding schools that sponsor international students: Schools should consider using all available means to safeguard children and make decisions that prioritise the child's welfare with the right plan made for each student.

Theme 5: Safeguarding and the role of education guardians and homestay hosts in the lives of international students

System Recommendation 9 for the Department for Education and the Secretary of State for Education: To make the regulation of education guardianship statutory through national minimum standards for the sector.

System Recommendation 10 - For AEGIS all education agents and schools that advise parents to appoint education guardians: To establish as best practice that a student should meet their appointed education guardian as the trusted adult appointed to care for them at a (virtual) meeting before coming to the UK.

Practice consideration H: In the absence of statutory regulation, for AEGIS to continue to ensure best practice in ensuring that education guardians safeguard children.

System Recommendation 11 - For the Department for Education: The DfE establishes a clear and unambiguous legal position and revises statutory guidance regarding education guardianship and homestays so that education guardians and/or those providing a homestay are considered as in a position of trust.

Theme 6: The safety of out-of-education residential programmes

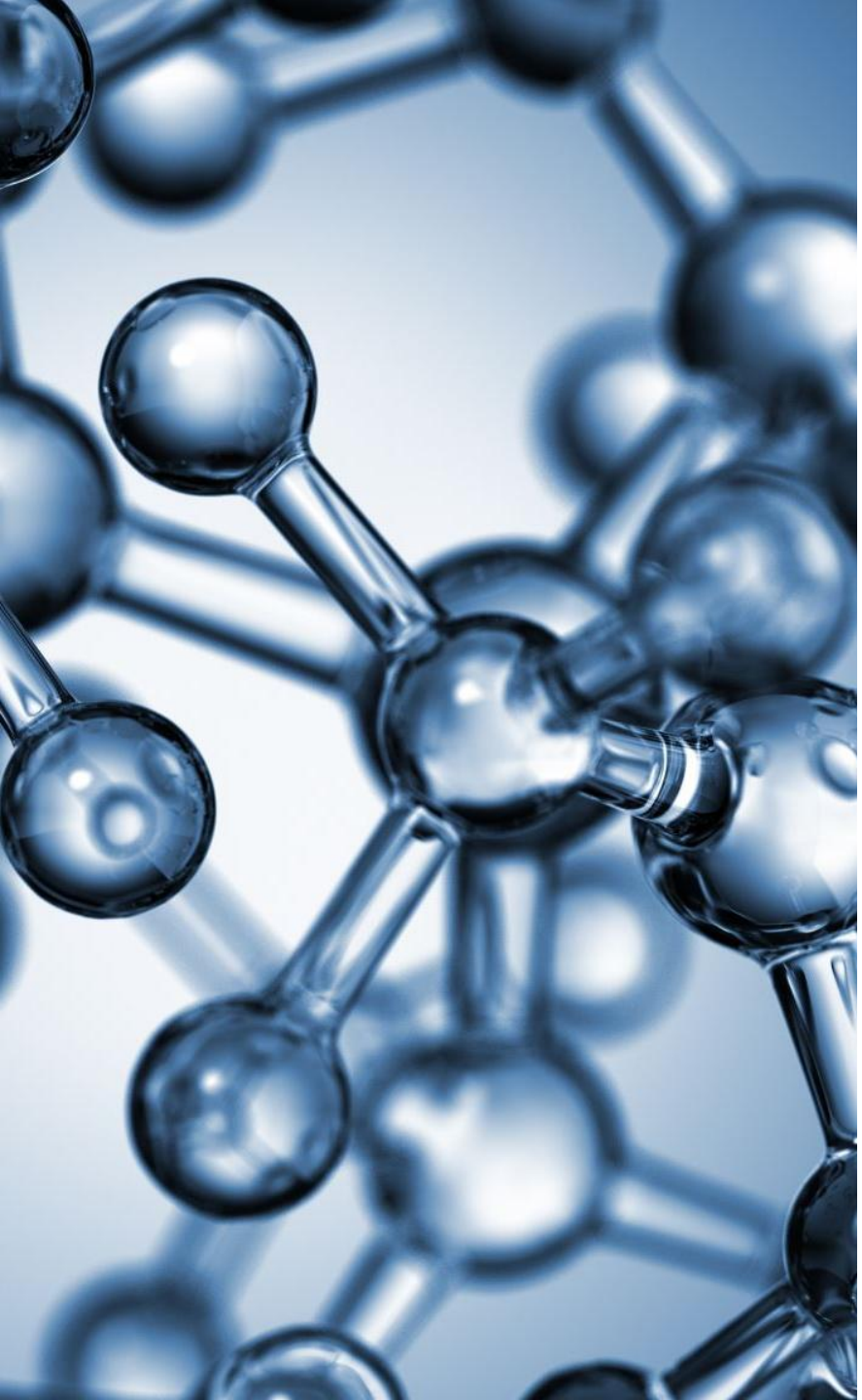
System Consideration for LSCPs: How to embed all this learning as relevant to all out-of-education residential programmes across the UK.

System Recommendation 12 for the Department for Education: Statutory regulations, supported by national minimum standards, are implemented across the out of education sector. To include as a minimum: Safeguarding policy; Application process, including multi-agency handover and transfer of information relating to additional needs; Admissions and registration; Risk assessment and management; Medication management, including storage and safe administration; Information management; Staff training and supervision; Supervision of students; Missing student responses; Provision of contact information for residents; All this information needs to be provided in languages and styles suitable for all students.

Addendum - Theme 1: CDOP Child Death Partners

System Considerations: The Child Death Review processes in both areas involved assimilating the learning from this review into their learning processes and annual reporting. Both LSCPs should lay out how this will be implemented. The LCSP to inform the coroner who conducted the inquest of this feedback from parents and participating agencies.

Telford and Wrekin Safeguarding PARTNERSHIP



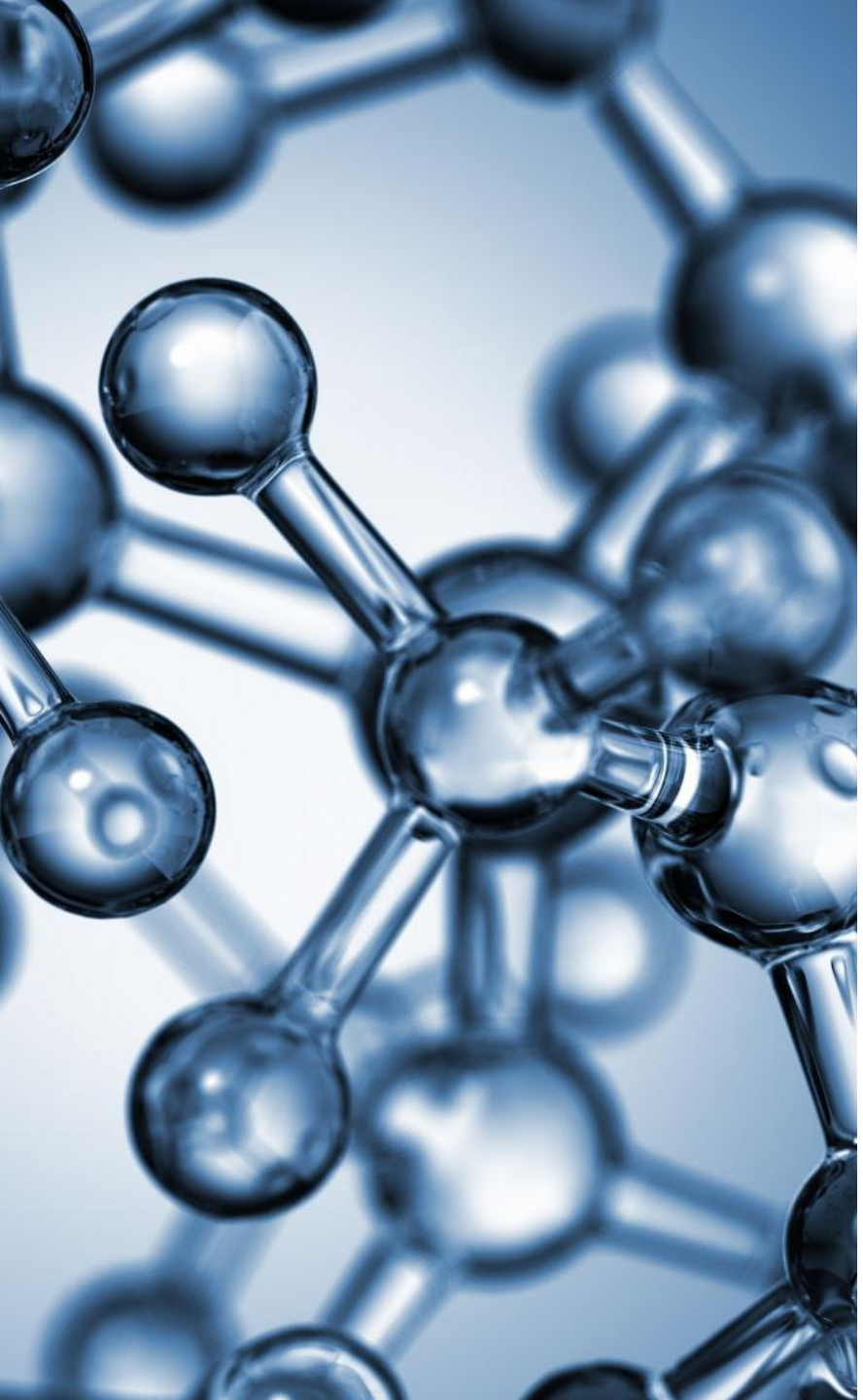
Learning from Domestic Homicide Reviews

DHR 2

DHR 3

DHR 4

DHR Jason



Learning from Safeguarding Adult Reviews

SAR Lou

SAR Patricia

SAR Violet

Safeguarding Adult Review – 'Lou' Learning Briefing

Telford and Wrekin Safeguarding PARTNERSHIP

1. Background - This case review considered the death of a 40 year old person who resided within supported accommodation. They received full-time care due to having disabilities and underlying health conditions including severe epilepsy which was eased with the use of a Vagus Nerve Stimulation (VNS). Sadly, the person passed away suddenly in late 2022.

4. Positive and proactive steps taken to address the recommendations so far -

In response to the initial recommendations, partner agencies within the Safeguarding Adults Review (SAR) Panel have taken meaningful and proactive steps to strengthen multi-agency collaboration and enhance safeguarding practice.

- **Strengthening Collaboration in Complex Cases:** Partner agencies are actively working to improve joint planning for individuals with complex needs. There is a shared awareness of Section 42 safeguarding duties, including the importance of timely communication of investigation outcomes.
- **Enhancing Risk Assessment through Shared Knowledge:** Updates to the social care risk assessment process are already underway, with a focus on clearly incorporating information from all relevant agencies. This ensures that risk assessments are comprehensive and person-centred.
- **Improving Care Plans and Quality Assurance:** Reviews of safeguarding assessment and referral forms are progressing to ensure Care Plans accurately reflect individual needs. Quality assurance engagement with care providers is ongoing to uphold and continuously improve the standard of care delivered.
- **Collaborating on Assistive Technology Assurance:** The Assistive Technology Team is partnering more closely with care providers to strengthen oversight and support around assistive technologies, helping ensure continuity of safe and effective care for those who depend on such equipment.
- **Raising Awareness Around Critical Incidents:** A guidance note is being prepared and will be shared with care providers to clarify responsibilities following unexpected deaths and in situations involving police investigations. This will help ensure appropriate actions are taken with sensitivity and professionalism.

2. Process

Following receipt of the referral in Winter 2022 scoping information was requested which informed the decision to progress to a Safeguarding Adult Review (SAR) in Spring 2023. Immediate safeguarding actions were implemented and an independent author was sourced in early summer 2023. This review was run alongside a LeDeR review process which avoided duplication of work for agencies and reduced the impact on the family. The review panel was made up of practitioners involved with the case alongside managers from across the partnership and met formally four times throughout the process, with additional theme specific meetings taking place in between. Contact was maintained with the family throughout to update them on the progress and allow opportunity for them to contribute at their own pace.

3. Recommendations and Learning

The following recommendations were made following the independent review:

1. Assurance should be sought around procedures reinforcing the need for a single multi agency plan to be developed in complex cases. If single agency reviews have taken place these should be shared with other agencies involved with the person. This should be audited regularly to ensure this is happening.
2. Assurance should be sought that the outcomes and recommendations from Section 42 enquiries are being shared at the earliest opportunity with all relevant organisations, including care providers.
3. Social Care should ensure that all guidance and templates address the issue of suitability of the care plan, taking into account identified risks such as fire or medical emergency.
4. The CQC and Social Care should use the findings of this review for future quality assurance of Home farm trusts provision Telford.
5. The assistive technology team should ensure clarity on roles and responsibilities of provision and maintenance of the equipment in cases where the care providers have their own technical support team, along with ensuring there is a contingency plan in place in case of equipment failure
6. Assurance should be sought that all care providers and community based professionals are aware of the 'acid test' in relation to DoL's criteria and the process to follow for identified cases.
7. Telford and Wrekin Safeguarding Partnership should remind care providers and agencies not to initiate any investigation following a death where there is police involvement.

Safeguarding Adult Review – 'Violet' Learning Briefing

Telford and Wrekin Safeguarding PARTNERSHIP

1. Background - This case review considered the death of Violet, a 75-year-old woman, in May 2024. She lived in a Wrekin Housing Group bungalow with her son, supported by her daughter and a care package delivered by an external agency (2 calls daily). Violet attended a day centre and enjoyed social activities. Her health conditions included reduced mobility, right-side weakness from strokes, and ulcerated legs. She used a wheelchair and required support for personal care. Violet died in hospital on 15 May 2024 following admission with sepsis and pneumonia.

4. Positive and proactive steps taken to address the recommendations so far - In response to the initial recommendations, partner agencies within the Safeguarding Adults Review (SAR) Panel have taken meaningful and proactive steps to strengthen multi-agency collaboration and enhance safeguarding practice.

- **Escalation Policies** It has been recognised by Telford and Wrekin Safeguarding Partnership that there is a need for a review of the Escalation Policies. This has been completed and re-circulated. The Partnership has also recognised a training gap to deliver training on the use of the escalation policy to ensure this is accurately recorded.
- Escalation Policy 2023-2025 - Telford and Wrekin Safeguarding Partnership
- **Multi Disciplinary Team Meetings:** Awareness shared across the Partnership regarding the role of the MDT. Specific training and flow chart to be developed and rolled out by the Partnership.

2. Process

The SAR was commissioned following Violet's death, meeting Care Act criteria. An independent author was appointed in December 2024. Evidence was provided by GP, Adult Social Care, Shrewsbury and Telford Hospital Trust, Shropshire Community Health Trust, West Midlands Ambulance Service, and Wrekin Housing Group. Combined chronologies and IMRs were collated.
A practitioner learning event in June 2025 allowed frontline staff to share insights into what went well, what could have been done differently, and how to improve practice.
The panel was made up of practitioners who knew the case alongside managers from across the partnership, the group met formally 4 times throughout the process.
The family have been updated and invited to be part of this review should they wish to do so.

3. Recommendations and Learning

The following recommendations were made following the independent review:

Recommendation 1. All agencies to ensure staff have an increased awareness of the role of the MDT and ensure staff make relevant referrals that meet the safeguarding threshold.
Recommendation 2. All agencies involved to ensure all staff are aware of escalation policies in their own agencies and utilise appropriately and also be aware that local authorities have their own escalation processes, should practitioners not agree with a decision that has been made.

Safeguarding Adult Review – 'Patricia' Learning Briefing

Telford and Wrekin Safeguarding PARTNERSHIP

1. Background - This briefing summarises the findings of the Safeguarding Adults Review into the case of Patricia, a 74-year-old woman who died in February 2024. The Review was commissioned because there was reasonable cause for concern about how agencies worked together to safeguard Patricia. Patricia's report highlights complex challenges of health and care needs, self-neglect, family responsibility, immigration status, and system response.

4. Positive and proactive steps taken to address the recommendations so far -

In response to the initial recommendations, partner agencies within the Safeguarding Adults Review (SAR) Panel have taken meaningful and proactive steps to strengthen multi-agency collaboration and enhance safeguarding practice.

- **Professional Curiosity:** Telford and Wrekin Safeguarding Partnership have developed Professional Curiosity training and briefings across the partnership. Shropshire Community Health Trust have developed their own specific training rolled out across the trust.
- Shropshire Community Health have improved record keeping and referral clarity and developed resources such as a 'permission to pause' video.
- **Professional curiosity 7 minute briefing developed:** Professional curiosity - Telford and Wrekin Safeguarding Partnership
- **Multi Disciplinary Team Meetings:** Awareness shared across the Partnership regarding the role of the MDT. Specific training and process flowchart to be developed and rolled out by the Partnership.
- **Easy access information on Self Neglect:** Agencies are to review what is in place in regards to Self Neglect offer for practitioners and case sampling shall take plan to review impact. 7 minute briefing completed by the Partnership. Self Neglect - Telford and Wrekin Safeguarding Partnership
- GP practice have introduced monthly searches for high-risk housebound patients and shared Patricia's case in clinical meetings.
- **Home Office to review information available around ancestry visa:** Contact has been made with the Home Office to share the learning and recommendations from this report.

2. Process

Following Patricia's death in February 2024, the SAR was commissioned under Section 44 of the Care Act. An independent author was appointed in December 2024.
Agencies contributing evidence included: GP, Adult Social Care, Shrewsbury & Telford Hospitals Trust, Shropshire Community Health NHS Trust, Midlands Partnership NHS Trust, and West Midlands Ambulance Service.
Chronologies, Individual Management Reviews, and reports were collated. A practitioner learning event was held in June 2025 to explore what went well, what could have been done differently, and how to improve practice.
The review panel was made up of practitioners involved in the case alongside managers from across the Partnership and met formally four times throughout the time of the review.
Throughout this process the family have been kept up to date with progress and allow opportunity to contribute should they wish to do so.

3. Recommendations and Learning

The following recommendations were made following the independent review:

Recommendation 1. All agencies to place a greater emphasis on professional curiosity. Need for partners to update training packages so that frontline staff place a greater emphasis about the value of exploring home circumstances/relationships further (Patricia was confined to her bed and unable to manage infected pressure sores and was generally not coping and her family were not able to manage this).
Recommendation 2. All agencies to ensure staff have an increased awareness of the role of the MDT and ensure staff make relevant referrals that meet the safeguarding threshold.
Recommendation 3. All agencies to ensure staff have easy access to information and assessment tools (such as self-neglect toolkit) this is vital as part of the ongoing support given to staff within all agencies working with adults at risk, to help them maintain their professional knowledge and understanding of complex safeguarding issues and where to go to get the help.
Recommendation 4. The Home Office to consider a review of information that is available to health and care professionals and families when applying for and being granted an ancestry visa. (The panel also recommended an easy read version).

Telford and Wrekin Safeguarding Partnership Toolkits and Best Practice Guidance

These toolkits/guidance have been developed by the Partnership, they aim to:

- Standardise Practice: They set out agreed processes and expectations for all partner agencies.
- Support Decision-Making: Offer step-by-step guidance for handling complex or contentious cases.
- Promote Collaboration: Encourage timely communication and joint problem-solving between agencies.
- Ensure Accountability: Define roles, responsibilities, and escalation routes to avoid drift or unresolved concerns.

Professional Curiosity Toolkit

The Professional Curiosity Toolkit is designed to help practitioners across agencies adopt a proactive, questioning approach when working with children, families, and vulnerable adults.

Purpose: Encourages practitioners to question, explore, and verify information rather than accept things at face value.

Key Focus: Helps identify hidden risks such as neglect, domestic abuse, or disguised compliance.

What It Provides:

Practical tips for asking deeper questions

.Reflective prompts (What am I being told? What might be missing?).

Guidance on overcoming barriers like assumptions or time pressures.

Outcome: Improves safeguarding by promoting critical thinking, respectful challenge, and timely escalation when concerns remain.

Access it here:

SAB Manager Network Professional Curiosity - Telford and Wrekin Safeguarding Partnership

Cultural Competence Guidance

Designed for practitioners involved in assessments, family plans, and care planning for adults, children, and families.

Aims to embed culturally competent practice across organisations, forming a basis for policy and service development.

Access it here:

Cultural Competence Guidance - Telford and Wrekin Safeguarding Partnership

Best Practice Guidance: Language in Practice

This guidance helps professionals in Telford & Wrekin use language that builds trust, reduces harm, and supports positive change for children, adults, and families. It draws on learning from safeguarding reviews and offers practical tips, principles, and alternative phrases to promote empathy, inclusion, and trauma-informed communication.

Access it here:

Best Practice Language Guide - Telford and Wrekin Safeguarding Partnership