

Safeguarding Leicester's Children Newsletter July 2018, Issue 5

Welcome to the 5th Issue of the Newsletter

Hello and welcome to this edition of the Leicester City LSCB newsletter! It's Adele here, I'm one of two Lay Board members who represents the community of Leicester. If you don't already know me, I am a staunch advocate for the protection of all children no matter their background, class, race, religion etc.

Since I have last written, we have had the Children and Young people Shadow Board/Young Advisors "Youth Proof" our website and produce a report with suggestions for improvement. I'm really looking forward to hearing more about it, many thanks to them for doing this.

Earlier on in the year, over three days, Board partners reported their safeguarding practices to a small panel for a Section 11 Peer Challenge Meeting, which I sat on for the second day. Alongside our Chair and one other Board partner, we heard the different safeguarding policies that partners have in place against the 9 required standards. It was really positive to hear so much good practice being displayed and to also make some suggestions for improvements.

Recently we have seen two very active Board members move on to other roles. Frances Craven from Children's Social Care and Simon Cure from Leicestershire Police. Their presences on the Board shall be missed and I wish them all the best in their new roles. I am looking forward to working together with their replacements in due course.

As you will be aware, Working Together legislation is ever changing. We need to stick together in these evolving and challenging times to ensure that we are all doing our up-most to protect the most vulnerable members in our society. Together we are stronger.

Whether you are going away or not, I hope you enjoy this glorious British summer!

All the best, Adele

This issue covers:

•	Working Together 2018
•	Leicester City Youth Festivals 2018
•	Child Sexual Exploitation
•	Private Fostering
•	Learning from Multiagency Learning and Improvement Review
•	LSCB Multiagency Familial Child Sexual Abuse Audit
•	Turning Point
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•	Further Information/Resources

Working Together 2018

Jenny Myers, Independent Chair of the LSCB, has welcomed contribution from partners to the newsletter and would like to draw your attention to Working Together 2018, which will impact on the future arrangements for safeguarding children and promoting their welfare.

The transitional arrangements for the LSCBs is for them to continue to carry out all their statutory functions until the safeguarding partners arrangements begin to operate in a local area. Until that time LSCBs and their partners should continue to refer to Working Together 2015, Chapter 3, Chapter 4 (disregarding the section on 'notifiable incidents' and references to the former National Panel) and Chapter 5.

The Local Children Safeguarding Boards (LSCBs) have been replaced through the Children and Social Work Act 2017. The statutory guidance, Working Together 2018 sets out the changes to the LSCBs and in the main these relate to:

- Creating new local safeguarding arrangements led by the three local safeguarding partners (Local Authorities, Chief Officers of the Police and Clinical Commissioning Groups).
- These three local safeguarding partners have a duty to make arrangements to work together and with any relevant agencies, for the purpose of safeguarding and promoting the welfare of children in their area.
- All three safeguarding partners have equal and joint responsibility for local safeguarding arrangements, which could cover one or more Local Authority areas.
- These local arrangements should link to other local strategic partnerships work and wellbeing boards.
- The local safeguarding partners must ensure that there is independent scrutiny of the effectiveness of local arrangements. They must publish the arrangements and report at least annually on what they have done as a result of the arrangements, including on child safeguarding practice reviews.
- Which relevant agencies, the three local safeguarding partners should work with in their area. Relevant agencies are those agencies/organisations whose involvement the safeguarding partners consider necessary to safeguard and promote the welfare of local children.

- The published arrangements much include the relevant agencies/organisations that the local safeguarding partners will be working with.
- All schools (including maintained, nonmaintained, independent, academies and free schools) and other education partners have duties relating to safeguarding children and promoting their welfare.
- The three safeguarding partners should agree funding from themselves, which should be equitable and proportionate, and contributions from the relevant agencies/organisations.
- Safeguarding partners may require any person or agency/organisation to provide them with specified information which they consider necessary to fulfil their functions to safeguard and promote the welfare of children in their area.
- A new system for national and local child safeguarding practice review will replace Serious Case Reviews. A national Child Safeguarding Practice Review Panel has been established, which has the responsibility to commission cases which raise issues that are complex or of national importance.
- Safeguarding partners will be responsible for identifying serious child safeguarding cases that raise important issues for their area, and commissioning and supervising reviewers for local reviews. The purpose of the local safeguarding practice reviews is to identify improvements to be made locally to safeguard and promote the welfare of children.
- The government policy for child death reviews and related issues will transfer from the Department for Education to the Department of Health. The Children and Social Work Act 2017 establishes the role of the child death review partners, which consists of Local Authorities and any Clinical Commissioning Group for the local area (as set out in the Children Act 2004, amended by the Children and Social Work Act 2017). Further Guidance will be published in relation to Child Death Review Arrangements.

The Working Together 2018 guidance available at: https://www.gov.uk/government/publications/wor king-together-to-safeguard-children The recently published Safeguarding Practitioners Information Sharing Advice is available at: https://www.gov.uk/government/publications/safe guarding-practitioners-information-sharing-advice

Leicester City Youth Festival 2018

This summer Leicester City Youth Service will be providing youth sessions, street-based youth work to young people aged 13-19 (up to 25 SEND) and a number of Youth Festivals across the City. This programme was launched on Saturday 14th July. The Youth Festivals will offer live music, interactives games and activities, information on local services for young people, Leicester City Football Club shootout, festival face painting, football zorbing and much, much more. For more information visit your local youth centre. Further details can be found at www.leicester.gov.uk/youthservices. Alternatively you can follow on Facebook @ Leicester City Youth Service or on Instagram @Leicester.youth.service.



Strictly no alcohol or drugs

Child Sexual Exploitation - What's Happening?

Breck's Last Game - Campaign Update

Many of you saw the first edit of *Breck's Last Game*, the three-minute film illustrating the true story of how 14-year-old Breck Bednar was groomed online and subsequently murdered in 2014. This will form the centrepiece of a major campaign aimed at raising awareness of CSE among boys.

Thank you to everybody who attended one of the screenings and gave your feedback - your input is very much appreciated.

The consultation period was a great success and we had some really valuable suggestions and advice about how to improve the film so that it really resonates with viewers and leaves a lasting impression which fulfils our remit to help protect young people from CSE and raise awareness of the dangers of online gaming. This has led to some quite substantial changes necessitating further filming sessions in June.

Because of this, the timetable for the launch of Breck's Last Game has changed slightly and the second edit will be available by 11 July and we will then gather further feedback for final editing during August.

The campaign and a trailer for the film will now be launched to the media on Wednesday, 19 September. The plan remains to roll the film into schools during the autumn term, and a supporting education pack will be created during the summer.

If you have any queries please contact claire.Tompkins@leicestershire.pnn.police.uk

Programme underway to raise awareness of child sexual exploitation within minority ethnic communities across Leicester, Leicestershire and Rutland (LLR)

A Faith and Communities Champion Service called 'Engage ME' has been contracted to deliver a community outreach and education programme within faith and minority ethnic communities in Leicester, Leicester and Rutland to raise awareness of child sexual exploitation. The programme is halfway through a 12-month contract and is being funded by the Office of the Police and Crime Commissioner.

Engage Me is an award-winning, UK-wide service which uses a culturally and faith-sensitive approach to support groups working with children and young people in order to adopt best practice in relation to safeguarding. The main objectives of this programme are:

- Supporting groups working with children and young people to adopt best practice related to safeguarding.
- Increasing awareness and understanding of abuse in all its forms and the ability to recognise signs of abuse.
- Increasing awareness and understanding of children's rights and the United Nations Convention on the Rights of the Child.

- Increasing awareness of measures that can be taken to prevent abuse.
- Empowering minority ethnic children and families to disclose abuse.
- Increasing awareness of relevant support services.

Engage Me staff have been working with minority groups across LLR to achieve these aims. They have already delivered 14 sessions to children and adults from the Bahai community, Krishna society, Muslim Community, Christian community, traveller and gypsy (Leicestershire GATE), Jain and Hindu communities. They are holding sessions for refugees and asylum seekers and they are also engaging with the Sikh community.

In addition, the team use a 'train the trainer' approach and have delivered training to 45 community champions who will continue the good work of the programme when the contract ends.

The sessions have been extremely well received as can be seen by the comments from participants are below.

Comments and Feedback



<u>Comments from children about what they learned</u> <u>from the session:</u>

- Always tell my mum and dad or tell an adult (if something doesn't seem right)
- Don't meet people I don't know
- I know more about how to stay safe
- Meaning of consent
- Don't accept strangers as friends

Comments from professionals, parents and carers

- Really interesting and ideas on ME cultural sensitivity eye opening.
- Very pleased with the training that was delivered today. I hope to utilise my skill set with my school.
- Points that stood out to me were the risks of social media, vulnerability of young people and the warning signs of grooming.
- My little sister was in the session on internet safety and keeping safe. She really enjoyed it and

was still talking about it the week after, thank you for your work.

An *Engage ME* spokesperson said: "We are delighted to be partnering with the Office of the Police and Crime Commissioner and the Federation of Muslim Organisations to bring this innovative approach to faith and community organisations within the LLR boundaries.

"Our programmes are co-designed by children and young people to ensure they will engage with them effectively. CSE can often be a taboo subject and we have been inspired by the appetite of local faith and community groups to engage with us in training, tackling stigma and barriers to reporting and accessing mainstream services.

"Having engaged successfully with so many diverse communities we are committed to keeping the momentum going and building on the foundations we have laid for future engagement on this and other relevant safeguarding issues."

Leicestershire's Police and Crime Commissioner, Lord Willy Bach, recognising the value of this programme, has provided the funding. He said:

"Protecting all the vulnerable members of our community is one of the most important elements of our work. This programme is helping young people from minority ethnic communities to be more aware of this repugnant and often unreported crime".

"No-one should suffer in silence and I hope that we can also encourage people to come forward and report their experiences. By increasing awareness of the dangers, what is right and what is wrong, is the best way we can help them and their families, to protect themselves."

Further information about engage me is available by contacting <u>info@engageme.org.uk</u>



Children are being exploited by gangs involved in drug crime. **Know the signs to spot.**

County lines gangs use children and vulnerable people to courier drugs and money. A young person who is involved in county lines activity might exhibit some of these signs:



In an emergency call **999** For non-emergencies call **101** Visit **www.leics.police.uk**

Help and advice:

Leicester City Council - **0116 454 1004** Leicestershire County Council - **0116 305 0005** Rutland County Council - **01572 758407**



Private Fostering – What do practitioners need to do?

A private fostering arrangement is one that is made without the involvement of the Local Authority to look after a child under the age of 16 (or under 18 if disabled) by someone other than a parent or close relative, for 28 days or more and can include those living with extended family members. So, this could be a child living with people as stated below:

Private Fostering includes a child living with:	Private Fostering does not include a child living with:
godparents	brothers
 great-grandparents 	• sisters
great aunts or uncles	 grandparents
family friends	• aunts
• step parents where a couple isn't married	• uncles
or in a civil partnership	 step parents where a couple is married or in
• cousins	a civil partnership
• a host family which is caring for a child	mother
from overseas while they are in education	• father
here	 children and young people who are being
	looked-after by the Local Authority

Private foster carers and those with Parental Responsibility are required to notify the Local Authority's Children's Social Care of their intention to privately foster or have a child privately fostered or where a child has been privately fostered in an emergency. This should be done six weeks before the arrangement takes place or immediately if it is unplanned or already happening. This is so the Local Authority can work with private foster carers to keep children safe and also support anyone who is privately fostering. The LSCB has produced information for carers in <u>Bengali</u>, <u>English</u>, <u>Gujarati</u>, <u>Polish</u>, <u>Punjabi</u>, <u>Somali</u> and <u>Urdu</u>, which is available on the <u>LSCB website</u>.

It is the Local Authority's duty to satisfy itself that the welfare of the children, who are privately fostered within their area, is being safeguarded and promoted. However, the Local Authority can only do so, when it becomes aware of a private fostering arrangement, as there may be such arrangements that have not come to their attention.

Anyone working with children and their families may become aware of children who are possibly living in a private fostering arrangement. **All practitioners and volunteers** therefore, have an important role in being alert to this and in notifying the Local Authority of **any** possible private fostering arrangement that comes to their attention. In addition, where a practitioner or volunteer is unable to establish or has any doubt whether the arrangement has already been notified to the local authority or where they have any doubts about whether a child's carers are their parents they should check this with the local authority.

Further information on <u>private fostering</u> is available on the LSCB website, which includes links to <u>Somebody Else's Child</u>, the leaflet on <u>information for professionals</u> and <u>LSCB multiagency safeguarding</u> <u>procedure referring to private fostering</u>

<u>LLR LSCB multiagency safeguarding procedures</u> are reviewed regularly and therefore practitioners should visit these frequently and <u>register for receiving alerts</u> when the procedure manual is updated

Learning from Multiagency Learning and Improvement Review - Brandon

Introduction

This summary/briefing is aimed at practitioners (and their managers) who are working with children, young people and their families in Leicester. It outlines the key messages from a learning and improvement review that was commissioned by the LSCB following the death of a 15-year-old child, Brandon, who sadly took his own life. Whilst there was no indication that Brandon had been subject to child abuse or neglect, this review was informed by the broader definition of safeguarding that reflects the provision of 'safe and effective care' in the context of family life and the delivery of services.

The review recognised the learning and improvements already instigated across local services in Leicester. Some of these changes relate directly to Brandon's experiences, whilst others have resulted from broader developments in services to children, young people and their families. This summary provides a short synopsis of the case and the learning points from the review.

What is the purpose of a multi-agency Learning and Improvement Review?

An independently-led multi-agency learning and improvement review may be commissioned by the Chair of a Local Safeguarding Children Board for cases that do not meet the full criteria for a serious case review (SCR) but where there are likely to be lessons to be learned in the way that individuals and organisations work together to safeguard and promote the welfare of children. The conduct of this type of review is outlined in statutory guidance Working Together (HM Government, 2015).

An important principle of such reviews is the need to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than with the benefit of hindsight. Family members, as well as practitioners, are invited to contribute to the findings.

What happened in this case?

Brandon had been diagnosed with a mixed anxiety and depressive disorder. At the time of his death he was not attending school and had become isolated from his friends. Concerns about bullying had been raised, and whilst the school found no evidence to support this, it appears that Brandon's perceptions and lived experience was of being a victim.

A significant feature of this complex case was that Brandon actively refused to engage with the services that were offered. This placed immense pressure on his family who were trying to support and help their son in very challenging circumstances. Services tried to be flexible, offering telephone, texting and written contact. Care was frequently provided 'via consultation with parents'. However, this may have reinforced his disengagement.

As Brandon's mental health deteriorated, professionals became aware of episodes of self-harm and his expressions of suicidal ideation. These were risk-assessed and although consideration was given to a period of in-patient care, clinicians did not believe that this would be in his best interest.

Despite the involvement of universal health services (GP and school nursing), a hospital emergency department and children's ward, child and adolescent mental health services (CAMHS), audiology services, the early help service, school staff, education welfare service, educational psychology, an alternative education service and the police service, Brandon's case became 'stuck' with little progress made in assessing the extent of his mental health needs and in ensuring his safety and recovery. Multi-agency work was not effective, there was drift and delay in specialist assessments, and the family were held captive by his illness.

Brandon's death has caused immense sadness to his family, friends and to his care providers. We should note the expert opinion, provided for the NHS serious incident review, that suicidal ideation is seemingly common, yet suicide is a rare outcome and extremely difficult to predict.

What is the key practitioner learning from this review?

Brandon's view of what was happening, and what would be helpful to him, was largely absent, due in part to the difficulty in engaging him in his care, but also in the drive to be responsive to the concerns as expressed by his parents.

The views and lived experience of the child should be central to care-planning and delivery. The use of an independent advocate is recognised as good practice, especially for those who are feeling threatened or vulnerable in accessing their mental health care.

The responsibility for ensuring engagement should rest with the practitioner, and not with the child or young person.

Whilst there was evidence of a high-level of contact between agencies and professionals, no one practitioner took the opportunity to fulfil a 'lead professional' role, bringing Brandon, his family and colleagues together to coordinate an agreed multi-agency assessment and plan with clear and timely outcomes and a focus on his recovery and return to school.

The role of lead professional should be undertaken by the practitioner best placed to do so. Their leadership should help to bring together an effective multi-agency team around the child and family. Consider how this role is supported by your agency.

Supporting young people with mental health crises is a role that should be shared with schools, primary care, children's social care and youth justice services, and is not a role for children's mental health services alone.

The importance of multi-agency support to children and young people with suicidal behaviour is reflected in the Leicester Safeguarding Children Board procedures. These highlight the importance of effective multi-agency relationships and good information sharing processes, so that the vulnerability and risk factors for individual children and young people may be properly understood and responded to.

At the time of Brandon's illness, a crisis, recovery and home-treatment team (CRHT team) for children and young people in the city was not in place. This service was introduced in April 2017.

Practitioners should ensure that they understand the services offered by the CRHT team and the mechanisms for referral for children and young people experiencing a mental health crisis (see below).

Brandon had been missing education for an extended period; a factor that was certainly raised as a concern by his parents. After it became clear that he was too unwell to attend his mainstream school, arrangements were made for input from a home tutor, with a view to attendance at the hospital school. There was considerable slippage in these arrangements as well as a delay in progressing an education and health care plan (EHCP) to inform this provision.

The LSCB has asked education leads to provide assurance regarding the process for monitoring the education of children who have low attendance at school and require alternative provision. Practitioners should be aware of children who are missing education and be proactive in ensuring that alternative provision is in place. Where an EHCP has been proposed, this should be completed in a timely manner.

The apparent sudden deterioration in his mental health and emotional wellbeing was clearly linked by Brandon and his family to bullying within the school. This factor has, in turn, been consistently recorded by those involved in his care. The allegations of bullying, including sexualised comments, were robustly investigated and addressed by the school.

Recent government guidance (see below) on bullying has raised the issue of 'banter' as a form of bullying. Practitioners working in education services should be aware of local policies and procedures for tackling this form of bullying.

LSCB Multiagency Familial Child Sexual Abuse Audit - What is the key learning?

Key learning is stated below – the audit summary/briefing is available at http://www.lcitylscb.org/information-for-practitioners/lscb-multi-agency-audits/

Key Findings/learning

- **Compliance** with procedures was variable. There was lack of understanding of People Posing Risks procedure and assessment tools, and local procedures were not followed consistently in all the cases and agencies. In one case, a child was used as an interpreter and practitioners need to be aware that this is inappropriate.
- **Case Recording** is still an issue. Language and religion were not consistently recorded in all the cases, although UHL and the Police found that correct details were recorded in the cases they audited
- Obtaining the 'voice of the child' and considering their lived experience was not consistent in all cases and across the partnership. In one case, regarding the child's lived experience, their cultural heritage and parentage of both parents and any impact was not considered fully. The child's lack of engagement was identified as an issue. However, practitioners should consider the child's situation, environment and contributing factors and pull this together with what the child is saying (or not) to consider what life is like for the child, to consider potential risk and protective factors to information safeguarding planning.
- **Referrals** were appropriate in most of the cases. In one case NPS notified CSC of the father's release from prison resulting in action for staff within NPS to check with CSC of involvement where an offender is appearing for sexual offence regardless of whether it is non-contact. In one case, had CSC considered the risk to sexual abuse in an earlier referral, it could have resulted in earlier intervention to safeguard the child
- Assessments were completed within the time scales by CSC and NPS. However, pre-birth assessments were not conducted by CSC in two cases of unborn children (one due to not receiving information in time and the other an initial referral was not appropriately responded to, resulting in the assessment not progressing until a further referral was made); identifying that the needs of the unborn children were not considered initially.
- Father's involvement -The father in the case audited by NPS was involved in the assessment process. Overall, greater awareness of involving and engaging with father/step fathers in assessments is required by practitioners.
- Escalation There was evidence of good challenge and escalation by practitioners and managers. In one case, there was challenge to CSC relating to risk to an unborn child not immediately assessed and in another the original judgement was overturned by the Service Manager.
- Genograms, chronology, research and tools A lack of genograms was identified by LPT in the cases they audited, and CSC identified that the quality of genograms and chronologies need improving. The use of relevant research and tools was not consistent across all cases and agencies. Where relevant CSE, THRIVE and DASH tools were used by the Police and CSC found that research was used well in some cases, but not all as there was limited reference to tools used in some. It was identified that *"There is a need for consideration of how to ensure PPRC [People Posing a Risk to Children] risk assessment are completed with reference to adults convicted of possessing indecent images of children".*
- **Category of children** Overall the children were registered under the appropriate category. In six of the cases, the children were on Child Protection Plans under the category of sexual abuse. A further two were on a Child Protection Plan under the category of neglect and in one of these, according to auditor, the risk of sexual abuse should have been included alongside neglect for the Child Protection Plan.
- Safety and contingency planning contribution from agencies and risk being addressed was evident in most of the cases, although the need for consistency in quality and robustness of Plans was identified
- **Good multi-agency working** was evident, but this was not consistent across all the cases and partnership. Issues relating to administration (meetings not held in time, meetings not recorded and notes not circulated) and contribution to multi-agency meetings was identified in a small number of cases.
- Attendance/contribution was identified as an issue in some cases, despite invitations to conferences.
- In one case, a persistent health issue identified by LPT, and a range of health issues noted in the GP audit, but there seemed to be a lack of correlation/analysis between both agencies of why this was the case, although the risk of sexual abuse appeared to be documented.
- Management and supervision was evident, but this needs to be more robust in some cases. The lack of participation of schools and education settings in the audit was noted.



Turning Point young people and young adult's service works across Leicester, Leicestershire and Rutland and can work with young people or young adults up until their 25th Birthday.

Turning Point offer services specifically aimed to engage with and support an individual's needs and will see young people in their home, at school or other outreach venues. They offer a non-judgmental service and are here to support young people.

Please see website for the services that Turning Point offer: <u>http://wellbeing.turning-point.co.uk/leicestershire/our-services/young-people/</u>

DUST – DRUG USE SCREENING TOOL

Research indicates that many factors can increase the risk of a young person moving from 'substance use' to 'substance misuse', whilst some protective factors can reduce these risks. Unless you are a specialist drug & alcohol worker it can be difficult to distinguish between 'use' and 'misuse'. The Drug Use Screening Tool (DUST) can help.

After the successful launch of DUST at City Hall on May 18th2018, Turning Point have scheduled a number of half day training events. This training will cover: basic drug awareness, completion of the DUST and how to refer to our Young People service. Venues are across the City and North & South of the County in an attempt to reach as many professional practitioners throughout Leicester, Leicestershire and Rutland. To register for this training please visit Eventbrite at <u>https://www.eventbrite.co.uk/d/united-kingdom–Leicester/events/</u> Search for Turning Point YP at either: Leicester, Loughborough, Market Harborough.

Access the training schedule through this link: <u>http://wellbeing.turning-</u> point.co.uk/leicestershire/2018/06/18/basic-drug-awareness-dust-completion-and-referral-process/

You can find out more about our youth service by calling 0330 303 6000 or by emailing YPandYAservice@turning-point.co.uk.cjsm.net

LLR LSCB Safeguarding Training and Learning – What's happening?

Hi All

Firstly, I would like to welcome Khalid Arif who has joined the team to support the work that we are doing in the Multi-Agency Training Group, much of which I talk about below.

I thought I should let you know what is happening...

- As you know the Multi-Agency Training Programme, coordinated by the LSCB has been under review. In addition, the support function to the programme, Strategy and Competency Framework have all also been subject to review.
- Multi-Agency Training Programme: this has been partially suspended for the months April - July 2018. Towards the end of July, you should be able to access the new programme via the **LSCB website**. This is a change as previously we would have advertised on the 'Children's Workforce Matters' website.
- For some people to access the new programme they will need to pay a fee, this will all be explained in the 'Charging Policy' which will also be published on the website towards the end of July.
- Linked to this is the **Safeguarding Learning**, **Development and Training Strategy** which sets out the expectations of the LSCB around Safeguarding learning, of those people within the children's workforce.
- And then linked again, and underpinning the Strategy is the **Safeguarding Children Competency Framework**. This framework has been revised following a consultation and then colleagues have had the opportunity to review and offer feedback on the new document through some workshops.
- The Competency Framework is now a much simpler document and has 10 Core Competencies for everyone; and then an opportunity to build a set of competencies according to role. We will aim to publish this at the same time as the above. There will also be some explanatory workshops available.
- In terms of 'Essential Safeguarding Awareness' training, this will not be delivered in the same way, but we hope to have some basic sessions, linked to the Competency framework.

If you have any questions at all about any of this – please do not hesitate to contact me Liz Dunn: 0116 454 2550 <u>elizabeth.dunn@leicester.gov.uk</u>

Thanks,

Líz

Further information/Resources

Action for Children - Research, resources and information <u>http://www.actionforchildren.org.uk/policy-</u> research

Barnardos - Research and information including fact sheets http://www.barnardos.org.uk/what_we_do/polic y_research_unit/research_and_publications.htm Sign up for regular Newsletter: http://www.barnardos.org.uk/email_subscription _form.htm

Leicester, Leicestershire and Rutland Safeguarding Children Boards' Procedures (staff can register to be alerted on updates) http://llrscb.proceduresonline.com/chapters/cont ents.html

National Children's Bureau - Policy, research and information https://www.ncb.org.uk/

National Working Group Network (NWG) – Tackling child sexual exploitation http://www.nwgnetwork.org/

National Referral Mechanism (NRM) - The Government's National Referral Mechanism guidance and referral forms can be accessed at the link below. The referral and assessment forms should be used to report potential victims of human trafficking

https://www.gov.uk/government/publications/hu man-trafficking-victims-referral-and-assessmentforms

NSPCC – Information, research, briefings and resources including the <u>National Repository of</u> <u>published Serious Case Reviews</u> https://www.nspcc.org.uk/

Office of the Children's Commissioner for England - Information, briefings and research on issues affecting children and young people, and includes the final report of the Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups (November 2013) http://www.childrenscommissioner.gov.uk

Research in Practice - Research, information and resources to support evidence informed practice <u>http://www.rip.org.uk/</u> (Leicester City Council employees can register using their work email address)

Safeguarding in Education - Further Information http://www.lcitylscb.org/safeguarding-learningdevelopment-training/safeguarding-in-education/

Further information about the LSCB

Information about the LSCB including the Board, sub-groups, information for children & young people, parents & carers and professionals including news, procedures and useful links see the LSCB <u>website</u>.

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